DY7-8 RHP Plan Update
Companion Document

Contents

Overview

The purpose of the RHP Plan Update is to reflect the DSRIP evolution from DY2-6 projects to DY7-8 provider-level outcomes. It will provide a crosswalk from a provider's DY2-6 discrete projects to the provider's system-wide activities intended to achieve outcome measures. In the RHP Plan Update, each provider will define their system for the purposes of DY7-8 DSRIP and report a baseline for the Patient Population by Provider (PPP). The RHP Plan Update is also the means for providers to select Measure Bundles or measures. Each RHP Plan Update is comprised of the region's Performing Providers' templates and one Anchor template. HHSC is not accepting separate narratives or documentation through the RHP Plan Update, with the exception of an optional Community Needs Assessment description if an Anchor prefers to submit one in addition to completing the questions in the Anchor template.

The templates allow entry and verification of DY7-8 requirements as defined in the DY7-8 Program Funding and Mechanics Protocol (PFM) and Measure Bundle Protocols (MBP), including the Measure Specifications. The current documents are posted on the HHSC waiver website under Waiver Renewal: https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-renewal

Note that DY9-10 requirements have not been developed and the RHP Plan Update is limited to DY7-8. HHSC plans to gather stakeholder feedback in late 2018 to develop DSRIP requirements for DY9-10.

The provider template will allow Performing Providers to:

- Update contact information.
- Indicate the primary county being served and any additional counties.
- Define the provider's system through selection of system components.
- Enter DY5-6 Medicaid and Low-income Uninsured (MLIU) Patient Population by Provider (PPP) and request use of DY5 or DY6 for calculating MLIU PPP goals for DY7-8.
- Select Measure Bundles/measures to meet or exceed the Minimum Point Threshold (MPT) otherwise the template will recalculate the provider's total valuation.
- Request measure volume changes, shorter or delayed baseline measurement periods, reporting milestone exemptions, and baseline numerators of zero for certain measures.
- Distribute Measure Bundle/measure valuation within the minimum and maximum requirements.
- For providers in regions with additional funding:
    - Enter an increased valuation that the template will calculate a revised MPT.
    - Enter information for new providers in a separate template.
- Update DY7-8 Intergovernmental Transfer (IGT) information.

The Anchor template will allow Anchors to:

- Update contact information.
- Enter information for UC-only hospitals, UC-only IGT Entities, and collaborating organizations, if applicable.

- Complete requirements for the Community Needs Assessment, stakeholder engagement, DY7-8 learning collaborative plan, and process for allocating additional funds, if applicable.
- Confirm whether the regional private hospital participation requirement was met.
- Review summaries of the provider templates including valuation, system components, MLIU PPP, and Category C selections.

All requests submitted in the RHP Plan Update are subject to HHSC and CMS approval.

Timeline

- February 8, 2018 - HHSC will hold a RHP Plan Update Template webinar. Please refer to the Transformation Waiver website for dial-in information.
- Date TBD - Anchors determine the date that their regional Performing Providers must submit their templates for Anchor compilation.
- February 28, 2018, 5:00pm - Anchors submit the completed RHP Plan Update including provider templates and the Anchor template to HHSC to be eligible for April DY7 reporting. Anchors must submit the files through SharePoint.
    - Please submit the two Anchor contacts (full name, email address that is an existing Microsoft account or linked to Office 365) for SharePoint access to TXHealthcareTransformation@hhsc.state.tx.us by February 16, 2018.
- April 30, 2018, 5:00pm - Final date for Anchors to submit the completed RHP Plan Update including provider templates and the Anchor template to HHSC. Anchors must submit the files through SharePoint.
    - Please submit the two Anchor contacts (full name, email address that is an existing Microsoft account or linked to Office 365) for SharePoint access to TXHealthcareTransformation@hhsc.state.tx.us by April 13, 2018.
- Approximately 30 days following submission of the RHP Plan Updates - HHSC will compile the submitted templates into a regional summary file, complete review of each RHP Plan Update, and will notify the Anchor of any requests for additional information using the regional summary file.
- By a date specified in the HHSC notification (approximately 14 days after the HHSC notification, 5 days for February submissions) - the Anchor will provide responses to HHSC requests for additional information in the regional summary file.
- Approximately 60 days following submission of the RHP Plan Updates (end of March for February submissions) and no later than June 30, 2018 - HHSC will approve or disapprove each RHP Plan Update.
- Estimated July 2, 2018 - IGT settlement date for DY7 RHP Plan Update submission payments and remaining 20 percent of DY6 Anchor payments.
- Estimated July 31, 2018 - Performing Providers and Anchors receive payments for RHP Plan Update submission.

DY7-8 RHP Plan Update - Provider Template

Each Performing Provider must complete a *RHP Plan Update Provider Template.*

Performing Providers that previously participated in DY2-6 in ***multiple regions*** must complete one provider template in their selected "home" region (with the exception of physician practices associated with academic health science centers that opted to continue in multiple regions with separate system definitions and will complete separate templates for each region).

For ***new providers*** in regions with additional funding, the separate, new provider template must be completed.

For providers with a ***limited scope of practice*** that are requesting an exemption from their calculated MPT or the Measure Bundle structure, additional instructions will be provided in February/March 2018 after the process for approving providers with limited scope of practice has been completed. Note that rural hospitals are not considered limited scope of practice. Do not complete the current template if you will be making a limited scope of practice request.

The provider template includes the following tabs:

- *Provider Entry* tab - requires selection of provider; entry of physical address and counties served; updates to contact information; indication of continuation in DY7-8; qualitative entry of provider participation in DY7-8; and confirmation of valuation.
- *Category B* tab - requires selection of system components and entry of MLIU PPP information.
- *Category C Selection* tab - requires selection of Measure Bundles or measures; allows requests to change measure volume for goal setting and achievement; and identifies if the selection requirements are met.
- *Category C Additional Details* tab - allows requests for shorter or delayed baseline measurement periods, reporting milestone exemptions, and baseline numerators of zero.
- *Category C Valuation* tab - allows updates to the distribution of Category C valuation among Measure Bundles/measures and requires justification for changes in valuation.
- *Category A Core Activities* tab - requires indication of whether a DY2-6 project was completed in DY2-6 or continuing as a Core Activity in DY7-8 and selection of Core Activities.
- *Category D* tab - displays the Statewide Reporting Measure Bundle measures and valuation.
- *IGT Entry* tab - requires confirmation of IGT Entities, updates to distribution of IGT funding, and certification by associated IGT Entities.
- *Summary and Certification* tab - summarizes the selection in previous tabs and requires certification of the selections.
- *Overall Template Progress* tab - summarizes the completion of items from each tab to determine if the full template is complete.

Each tab includes *Progress Indicators* to track completion of the required items within the tab.

Technical notes regarding the template:

- To ensure the template works properly, please be sure to click the *Enable Macros* button if it pops up upon opening the file. Also, confirm that workbook calculations are set to *Automatic.* (Under the *File* tab in Excel, click *Options*, followed by *Formulas*. Under *Calculation Options*, select *Automatic for Workbook Calculation*. Or under the *Formulas* tab, click on *Calculation Options* and select *Automatic*.)
- If there are pop-ups to *Enable Editing, Enable Content,* or *Do you want to make this a trusted document***,** select to enable/allow for the template to function properly.
- If you would like to copy and paste text from another document, please double click in the cell you are trying to paste into before pasting.
- Please note that it may take one or two seconds for the template to calculate after making an entry. If an error occurs, please try to redo the most recent action and wait a few seconds.
- If you would like to print pages, then go to *Page Layout* → *Page Setup*, and change the scaling and/or the orientation to fit according to your needs.
- Another way to view dropdown options is to click on a cell and use 'Alt' + [Down arrow key].

If you encounter problems with the template, please contact the waiver mailbox at TXHealthcareTransformation@hhsc.state.tx.us with SUBJECT: RHP Plan Update Template.

Step-by-Step Instructions for Completing the Provider Template

The format of the cells in the template correspond to the following:

Input cell (required)
Pre-populated (provider CANNOT edit)
Pre-populated (but provider CAN edit)
Optional

Note that the steps below in **red** font apply to all providers. Steps in **orange**, **green** and **magenta** font only apply to certain providers.

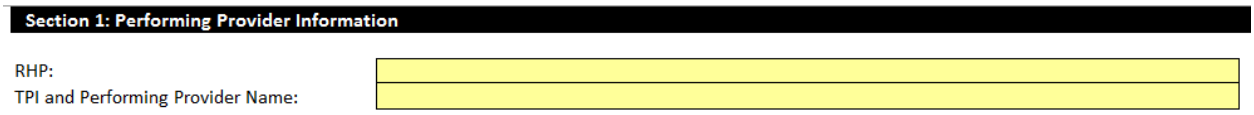
Please complete the steps in order within each tab, otherwise there may be calculation errors with the template.

A. *Provider Entry* tab

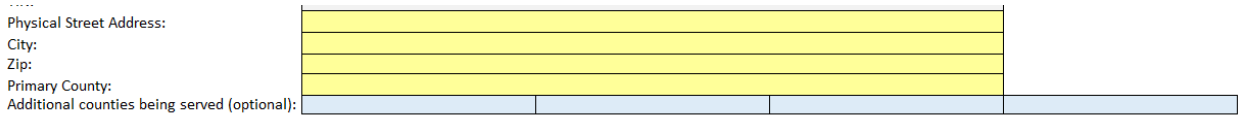
This tab requires entry of physical address and counties served; allows updates to the lead contacts; provides an option to withdraw from DSRIP; requires entry of provider description, goals, and alignment with the community needs assessment; and allows limited changes to valuation.

Performing Provider Information

Step 1 **-** Select your RHP and TPI. The TPI/Provider Name will auto-fill with providers in the selected RHP.



Step 2 **-** Enter your physical address and the primary county you serve. The primary county is likely where your main offices are located and this information will be used for reporting purposes to external stakeholders such as the legislature. *Optional* - please enter up to 20 additional counties where you provide the majority of your services and that you would want included in external reports to capture your larger service area.



Lead Contact Information

Step 3 **-** The lead contacts (up to three) are populated based on historical information. Please update the contacts as needed. Please note that a contact designated "Lead Contact" will be included in the RHP Plan and on the DSRIP Provider Distribution List. A contact designated as "Both" will be included in the RHP Plan, on the DSRIP Provider Distribution List, and will be given access to the DSRIP Online Reporting System.

Note that if you double-click on a cell, the contents will be erased due to formulas used to populate the field.

Only one Lead Contact in any of the columns is required to show as Complete.

Section 2: Lead Contact Information

	Lead Contact 1	Lead Contact 2	Lead Contact 3
Contact Name:			
Street Address:			
City:			
Zip:			
Email:			
Phone Number:			
Phone Extension:			
Lead Contact or Both:			

Optional Withdrawal From DSRIP

Step 4 **-** A provider may choose to withdraw from DSRIP through the RHP Plan Update. Select "Yes - Withdraw from DSRIP" or "No - Do Not Withdraw from DSRIP".

Section 3: Optional Withdrawal From DSRIP

Please select an option below. By selecting "Yes - Withdraw from DSRIP," this organization acknowledges it understands that any DY6 DSRIP payments will be recouped as required by the DY6 Program Funding and Mechanics Protocol. This does not include recoupment of DY4-5 payments that may have occurred in DY6 due to allowable carryforward.

If you selected to continue in DSRIP, then please continue to Step 5.

Step 4A **-** If you choose to withdraw, any DY6 DSRIP payments will be recouped as required by the DY6 Program Funding and Mechanics Protocol. This does not include recoupment of DY4-5 payments that may have occurred in DY6 due to allowable carryforward. Please respond to the following questions and the template is considered complete.

Please provide an explanation for the withdrawal

Please provide lessons learned in implementing DSRIP

Please provide an explanation of the close out of DSRIP

Performing Provider Overview

Step 5 **-** Enter a provider description, overall DSRIP goals, and how your DSRIP goals and activities are aligned with the regional community needs assessment. A minimum of 150 characters is required in these fields. If you would like to copy and paste into these fields from a separate document, then double-click in the yellow cell before pasting. ***At most***, enter two to three brief paragraphs for each field. The cell will only expand up to 26 lines.

Section 4: Performing Provider Overview	
Performing Provider Description:	
Overall DSRIP Goals:	
Alignment with regional community needs assessment:	

DY7-8 DSRIP Total Valuation

The DSRIP valuation across Categories is displayed based on whether or not the regional private hospital participation requirement is met. The amounts are based on DY6 valuation and additional funding from DSRIP projects withdrawn between June 30, 2014 and June 30, 2016 or DSRIP projects that HHSC determined were ineligible to continue in DY6 but the funds may be used in DY7-8.

Step 6 **-** Select "Yes" or "No" if you would like to decrease valuation. Providers may choose to decrease valuation based on available IGT or other reasons. The difference in lowered funds is no longer available to the provider or the region.

Section 5: DY7-8 DSRIP Total Valuation

	DY7-8 DSRIP Valuation Distribution			
	Valuation if regional private hospital participation requirement is met		Valuation if regional private hospital participation requirement is not met	
	DY7	DY8	DY7	DY8
RHP Plan Update Submission	$500,093.60	$0.00	$500,093.60	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$250,046.80	$250,046.80	$250,046.80	$250,046.80
Category C	$1,375,257.40	$1,875,351.00	$1,625,304.20	$2,125,397.80
Category D	$375,070.20	$375,070.20	$125,023.40	$125,023.40
Total	$2,500,468.00	$2,500,468.00	$2,500,468.00	$2,500,468.00

Would you like to decrease the total valuation?
No

If "Yes" is selected, then please enter the updated lower valuation to recalculate the amounts across Categories and update the MPT. The amount entered is applied to each DY. The adjusted MPT is based on the same formula stated in the PFM Protocol paragraphs 17.r. and 18.l.

Would you like to decrease the total valuation?
Yes

Please enter the updated decreased total valuation per DY.
$2,000,000.00

	Adjusted DY7-8 DSRIP Valuation Distribution			
	Valuation if regional private hospital participation requirement is met		Valuation if regional private hospital participation requirement is not met	
	DY7	DY8	DY7	DY8
RHP Plan Update Submission	$400,000.00	$0.00	$400,000.00	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$200,000.00	$200,000.00	$200,000.00	$200,000.00
Category C	$1,100,000.00	$1,500,000.00	$1,300,000.00	$1,700,000.00
Category D	$300,000.00	$300,000.00	$100,000.00	$100,000.00
Total	$2,000,000.00	$2,000,000.00	$2,000,000.00	$2,000,000.00

Original MPT:	6
Adjusted MPT based on updated valuat	4

Step 6A **-** If you are in a region with additional funds available (RHPs 1, 2, 4, 5, 8, 17, 18, 20) and through the regional process, you have been allocated additional funds, then please select "Yes" for increasing your valuation and enter the updated higher valuation to recalculate the amounts across Categories and update the MPT. The amount entered is per DY. Note that there is no limit on the amount entered so please contact your Anchor to confirm if you were allocated additional regional funds.

Note that this is not an opportunity to increase valuation outside the regional process. Please contact your Anchor if you have questions about how additional funds were allocated within your region. If you enter the incorrect amount and begin completing other tabs, then you will need to redo the entire template.

Based on the RHP's process for distributing additional funds, has the RHP approved increasing your valuation?

Yes

Please enter the updated increased total valuation per DY.

$3,500,000.00

	Adjusted DY7-8 DSRIP Valuation Distribution			
	Valuation if regional private hospital participation requirement is met		Valuation if regional private hospital participation requirement is not met	
	DY7	DY8	DY7	DY8
RHP Plan Update Submission	$700,000.00	$0.00	$700,000.00	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$350,000.00	$350,000.00	$350,000.00	$350,000.00
Category C	$1,925,000.00	$2,625,000.00	$2,275,000.00	$2,975,000.00
Category D	$525,000.00	$525,000.00	$175,000.00	$175,000.00
Total	$3,500,000.00	$3,500,000.00	$3,500,000.00	$3,500,000.00

Original MPT:	6
Adjusted MPT based on updated valuat	7

Step 7 **-** Select "Yes" if you have confirmed the valuations and IGT to fund the DSRIP amounts.

Have you reviewed and confirmed the valuations listed in the table above and identified available IGT to fund these DSRIP amounts?

Yes

Generate Worksheets

Step 8 **-** If you have completed the *Provider Entry* tab, then click the "Generate Worksheets" button. If you have not completed the tab, then there will be an error message that will not allow you to move forward and generate worksheets.

Note that after you click this button, you will no longer be able to make changes in the selected provider or valuation amounts that is accounted for in the later tabs. If you attempt to make changes and re-generate tabs, then there will be errors in the data and template. If there is a runtime error, you will need to close out of Excel and begin from a new template.

B. *Category B* tab

This tab requires selection and description of required and optional system components and entry of MLIU baseline information.

System Definition

DSRIP is shifting from project-based reporting to system-level reporting and a focus on system-wide changes and quality outcomes for DY7-8. As such, each Performing Provider is required to define its system in the RHP Plan Update for its RHP.

A performing provider's system definition should capture all aspects of the performing provider's patient services. The PPP is intended to reflect the universe of patients served by the performing provider's system, and therefore, the performing provider's system definition should incorporate all aspects of its organization that serve patients. The system definition may not exclude certain populations (with the exception of incarcerated populations served by hospital systems under contract with a government entity). The system definition should include all of a performing provider's service arenas that will be measured in its Category C measures, but may not be limited to those populations or locations if other services are provided by the performing provider.

There are required and optional components of a performing provider's system definition for each performing provider type. The required components are elements of a system that, through discussion with stakeholders and the technical advisory team, are common to a specific provider type; it has been determined that these components are essential functions and/or departments of the provider type. Therefore, the required components must be included in a performing provider's system definition if the performing provider's organization has that business component. A performing provider should also include optional components in its system definition and patient count if those components provide patient services. Contracted partners for certain services are completely optional to include in the system definition, but should be included if a provider intends to utilize data from the partner for Category C reporting purposes. Unless otherwise granted permission from HHSC, a performing provider should not count within its system definition or patient population another DSRIP performing provider's required components. There may be overlap in system definition for contracted partners; for example, System A that contracts with FQHC A and System B that contracts with FQHC A may both count the FQHC A as part of their system definition.

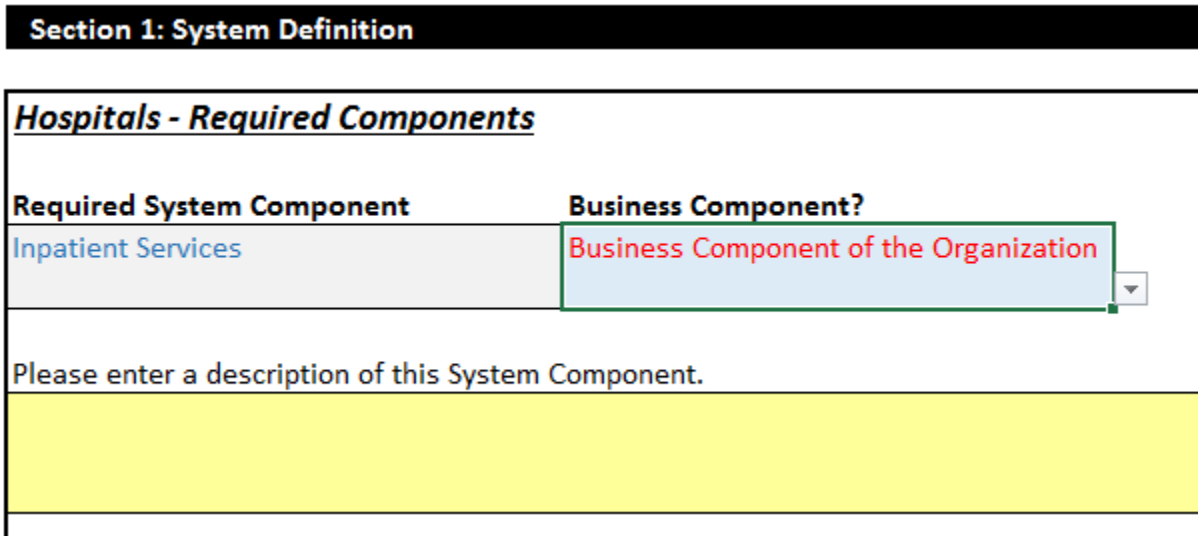
Please refer to the *Category B Frequently Asked Questions (FAQ)* posted on the DSRIP Online Reporting System Bulletin Board for additional information on system definition https://dsrip.hhsc.texas.gov/dsrip/viewBulletinBoard.

Step 9 **-** Based on your provider type, the required and optional system components have been populated.

For each required component, indicate if it is a *Business Component of the Organization* or if it is *Not a Business Component of the Organization*.

If it is a business component, then enter a description of the required system component. For example, using the Hospital Required Component of Inpatient Services below as a model, the description could be "all services in all units [excluding the women's maternity unit] to which a patient may be admitted to the hospital for general medical or surgical care, including diagnostic and therapeutic services."

If it is not a business component, then move on to the next system component.



For each optional system component, indicate if you would like to include it in the system definition.

If "Yes", then enter a description of the optional system component. For example, using the Hospital Optional Component below of Contracted Specialty Clinics as a model, a provider description would indicate the name of the contractor (such as Orthopedic Specialists of Wichita Falls), and the specialty services that it provides (orthopedic diagnosis, physical therapy, surgery, etc.). If a provider will only be counting patients who receive specific services under the contract, the provider should indicate that here. For example, if the hospital contracts with an FQHC for prenatal services exclusively, the hospital is not required to count in the PPP those patients receiving well-check visits at the FQHC that are not receiving prenatal services. This should be clarified in the description.

If "No", then move on to the next optional system component.

Hospitals - Optional Components

Optional System Component	Would you like to select this component?
Contracted Specialty Clinics	Yes

Please enter a description of this System Component.

Note that up to five *Other* system components may be entered under optional system components.

Optional System Component	Would you like to select this component?
Other	Yes

Please list your "Other" system component.

Please enter a description for this "Other" system component.

Medicaid Low-income Uninsured (MLIU) Patient Population by Provider (PPP)

As DSRIP shifts from project-level reporting to system-level reporting, HHSC wants to ensure that providers maintain a focus on serving the target population: MLIU patients. Because DSRIP reporting will no longer be project-specific, HHSC is requesting that providers demonstrate that they are maintaining a certain level of service to the MLIU target population in DY7-8. In addition, HHSC does not want providers to stop serving the MLIU population in an effort to enhance achievement on Category C measures. The Category B system definition and Patient Population by Provider (PPP) is meant to define the universe of patients that will be served by a Performing Provider.

For purposes of PPP, an individual is a patient receiving a face-to-face or virtual encounter (a service, billable or not) that is the equivalent of a service that would be provided within the physical confines of the defined system. This could include home-visits or other venue-based services that are documented. The service should be billable or charted. Providers are not allowed to count phone calls, text messages, or encounters that are not documented.

Please refer to the *Category B Frequently Asked Questions (FAQ)* posted on the DSRIP Online Reporting System Bulletin Board for additional information on PPP reporting https://dsrip.hhsc.texas.gov/dsrip/viewBulletinBoard.

Step 10 **-** Enter the MLIU PPP and Total PPP for DY5 and DY6. The template will calculate the average of DY5 and DY6 to use as the MLIU PPP goal for DY7 and DY8. Indicate the population that was included in the DY5 and DY6 MLIU PPP.

Note that the MLIU percentage is for informational purposes and will help HHSC determine allowable MLIU PPP variation. HHSC is not requiring the providers maintain or increase the MLIU percentage of their total population; providers are only required to maintain or increase the average DY5-6 number of MLIU patients served in DY7 and DY8.

Section 2: Medicaid Low-income Uninsured (MLIU) Patient Population by Provider (PPP)

	DY5	DY6
MLIU PPP		
Total PPP		

Please indicate the population included in the MLIU PPP

☐ Medicaid	☐ Dual Eligible (Medicaid and Medicare)	☐ CHIP	☐ Local Coverage Option (Below 200% FPL)	☐ Insured on the Exchange (Below 200% FPL)
☐ Low-Income (Below 200% FPL)	☐ Self-Pay	☐ Uninsured	☐ Other (explain to the right)	

MLIU PPP Goal for each DY (DY7 and DY8):	
Average Total PPP	
MLIU percentage of Total PPP	

*The MLIU percentage is for informational purposes and will help HHSC determine allowable MLIU PPP variation.

Step 11 **-** You may request to use DY5 or DY6 for the MLIU PPP goal instead of the average of DY5 and DY6. If making this request, then enter a reason for the request. This request is subject to approval by HHSC and therefore the reason should be significant. Possible demographic changes that could happen in the future or intentional ending of a particular program is not an approvable reason.

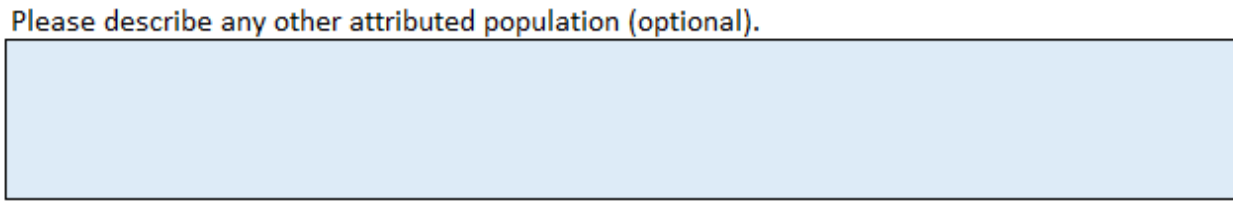
Would you like the MLIU PPP Goal to be based on DY5 or DY6 only (as opposed to the average)?	**Yes - DY5 Only**
DY5 MLIU PPP	1000
DY5 Total PPP	1500

Please provide a reason for requesting a different MLIU PPP Goal.

C. *Category C Selection* tab

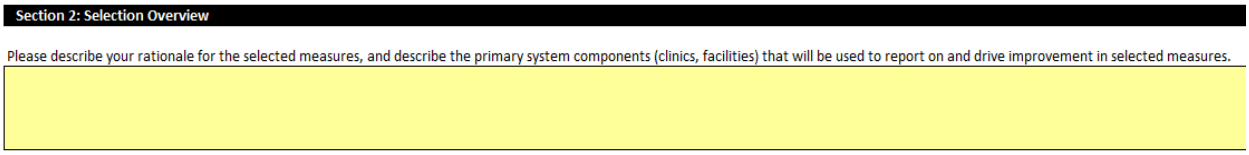
This tab allows selection of Measure bundles/measures, entry of why the Measure Bundles/measures were selected, and requests to change measure volume for goal setting and achievement. The tab identifies if the selection requirements and MPT are met according to the provider type. Providers should refer to the Measure Bundle Protocol for a detailed description of Category C, measure bundles and measures, and the approved attribution methodology for selected measures.

Step 12 **-** The attributed population based on provider type is displayed in Section 1. Please enter any additional other attributed population that will be included.



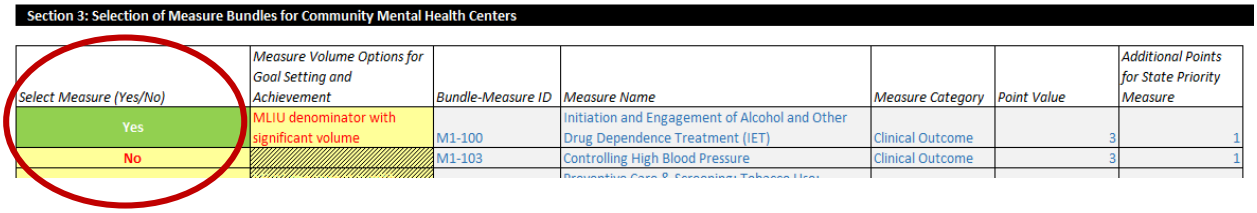
Selection Overview

Step 13A **-** For Community Mental Health Centers (CMHCs) and local health departments (LHDs), enter a rationale for selecting the measures and the primary system components (names of clinics, facilities that will serve as the primary source of the denominators for measures in the selected measures) that will be used to report on and drive improvement in selected measures. Please describe the process used to select measures, how selected measures align with your overall DSRIP goals and identified regional community needs, and contribute to the continued transformation of the healthcare delivery system.



Selection of Measure Bundles or Measures

Step 13B **- For CMHCs and LHDs**, select measures by indicating *Yes* under "Select Measure (Yes/No). Note that a measure may only be selected if it has significant volume (defined, for most outcome measures, as a denominator for the measurement period that is greater than or equal to 30).

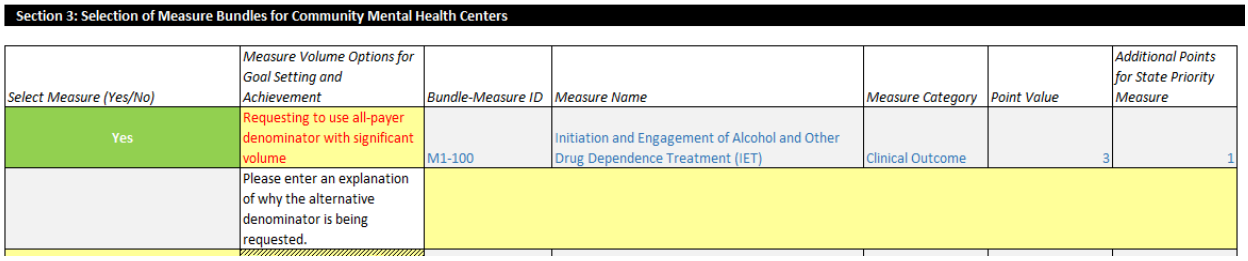


Section 3: Selection of Measure Bundles for Community Mental Health Centers

Select Measure (Yes/No)	Measure Volume Options for Goal Setting and Achievement	Bundle-Measure ID	Measure Name	Measure Category	Point Value	Additional Points for State Priority Measure
Yes	MLIU denominator with significant volume	M1-100	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Clinical Outcome	3	1
No		M1-103	Controlling High Blood Pressure	Clinical Outcome	3	1

Step 13C **-** For each measure, you may request to use a different measure denominator for goal setting and achievement (*all-payer denominator with significant volume, Medicaid-only denominator with significant volume, or LIU-only denominator with significant volume*). If an alternative denominator is requested, then enter an explanation for the request including a detailed description of the measure's baseline denominator for all-payer, Medicaid, and uninsured if known and data limitations if applicable.

Note that if you change the measure selection to "No" and had requested a different measure denominator, the explanation box will not automatically hide. To hide, please change the "Measure Volume Options for Goal Setting and Achievement" to *MLIU denominator with significant volume* and then change the selection of the measure to "No".

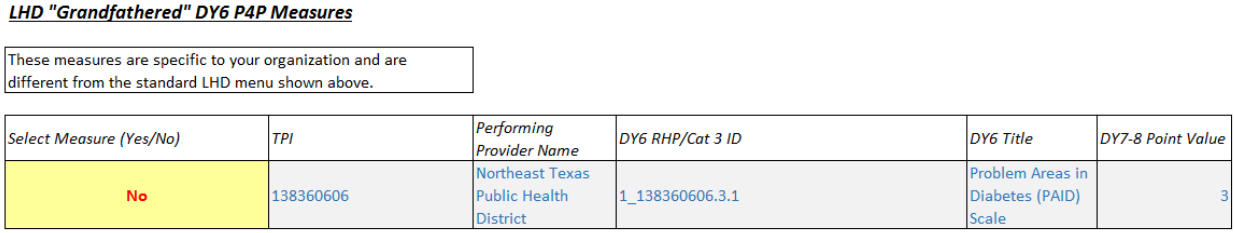


Section 3: Selection of Measure Bundles for Community Mental Health Centers

Select Measure (Yes/No)	Measure Volume Options for Goal Setting and Achievement	Bundle-Measure ID	Measure Name	Measure Category	Point Value	Additional Points for State Priority Measure
Yes	Requesting to use all-payer denominator with significant volume	M1-100	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Clinical Outcome	3	1
	Please enter an explanation of why the alternative denominator is being requested.					

Step 13D **-** For LHDs, the "grandfathered" DY6 pay-for-performance (P4P) measures are displayed beneath the LHD menu. The measures are specific to each LHD organization. Select a "grandfathered" measure by indicating *Yes* under "Select Measure (Yes/No)".

Note that duplicated measures will only count once towards the MPT. For example, if an LHD has two standalone (3 point) measures that are the same measure selection in DY6 but report different rates for different facilities, the LHD may continue to report both measures, but both measures will only contribute 3 points towards the MPT.



LHD "Grandfathered" DY6 P4P Measures

These measures are specific to your organization and are different from the standard LHD menu shown above.

Select Measure (Yes/No)	TPI	Performing Provider Name	DY6 RHP/Cat 3 ID	DY6 Title	DY7-8 Point Value
No	138360606	Northeast Texas Public Health District	1_138360606.3.1	Problem Areas in Diabetes (PAID) Scale	3

Step 13E **-** For CMHCs and LHDs, the minimum requirements include the following and are built into the template functionality:

- Selection of at least two unique measures.
- For CMHCs and LHDs with a valuation of more than $2,500,000 per DY, at least one 3 point clinical outcome measure must be selected. Clinical outcomes are identified under "Measure Category".

The *Progress Tracker* at the top of the *Category C Selection* tab displays whether the minimum requirements are met and the selected points compared to the MPT. Note that if a CMHC selects more than one of the depression response measures M1-165, M1-181, or M1-286, only 4 points will be counted towards the Performing Provider's MPT.

Progress Tracker

		Note: you must	MPT	6
Section 1: Selection Overview (CMHCs and LHDs only)	Incomplete	confirm	Points Selected	0
Section 2: Selection of Measures for Local Health Departments	Incomplete	selections at the	Measures Selected	0
Minimum Selection Requirements Met	No	bottom of the	Clinical Outcome Selected	N
MPT Met	No	page to finish.	At least 2 measures selected	N

Step 13F **- For hospitals and physician practices**, select measures by indicating *Yes* under "Select Measure Bundle (Yes/No). The base points for each Measure Bundle are displayed. Note that the base points are not recalculated based on selection of optional measures. Refer to the *Points Selected* in the header for the total selected points.

Section 2: Selection of Measure Bundles for Hospitals and Physician Practices

Measure Bundles for Hospitals & Physician Practices

Select Measure Bundle? (Yes/No)	Measure Bundle ID	Measure Bundle Name	Measure Bundle Base Points
No	A	Improved Chronic Disease Management: Diabetes Care	11
No	A2	Improved Chronic Disease Management: Heart Disease	8
No	B1	Care Transitions & Hospital Readmissions	11
No	B2	Patient Navigation & ED Diversion	3

Step 13G **-** Enter a rationale for selecting the Measure Bundle and the primary system components (names of clinics, facilities that will serve as the primary source of the denominators for measures in the selected Measure Bundles) that will be used to report on and drive improvement in the Measure Bundle. Please describe the process used to select measures, how selected Measure Bundles align with your overall DSRIP goals and identified regional community needs, and contribute to the continued transformation of the healthcare delivery system.

Please describe your rationale for selecting this Measure Bundle, and describe the primary system components (clinics, facilities) that will be used to report on and drive improvement in this Measure Bundle.

Step 13H **-** Select optional measures in the Measure Bundle by indicating *Yes* under "Select Optional Measure (Yes/No)".

Select Optional Measure (Yes/No)	*Measure Volume Options for Goal Setting and Achievement*	*Bundle-Measure ID*	*Measure Name*	*Required vs. Optional*	*P4*
N/A - Required	Medicaid-only denominator with significant volume	E1-232	Timeliness of Prenatal	Required	P4
N/A - Required	MLIU denominator with significant volume	E1-235	Post-Partum Follow-Up and Care Coordination	Required	P4
N/A - Required	MLIU denominator with significant volume	E1-300	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)	Required	P4
No	[illegible]	E1-193	Contraceptive Care – Postpartum Women Ages 15–44 (CCP-AD)	Optional	P4

Step 13I **-** For each measure, you may request to use a different measure denominator for goal setting and achievement with good cause, such as a small denominator or data limitations (*All-payer denominator with significant volume, Medicaid-only denominator with significant volume, or LIU-only denominator with significant volume*). If an alternative denominator is requested, then enter an explanation for the request including a detailed description of the measures baseline denominator for all-payer, Medicaid, and uninsured if known and data limitations if applicable.

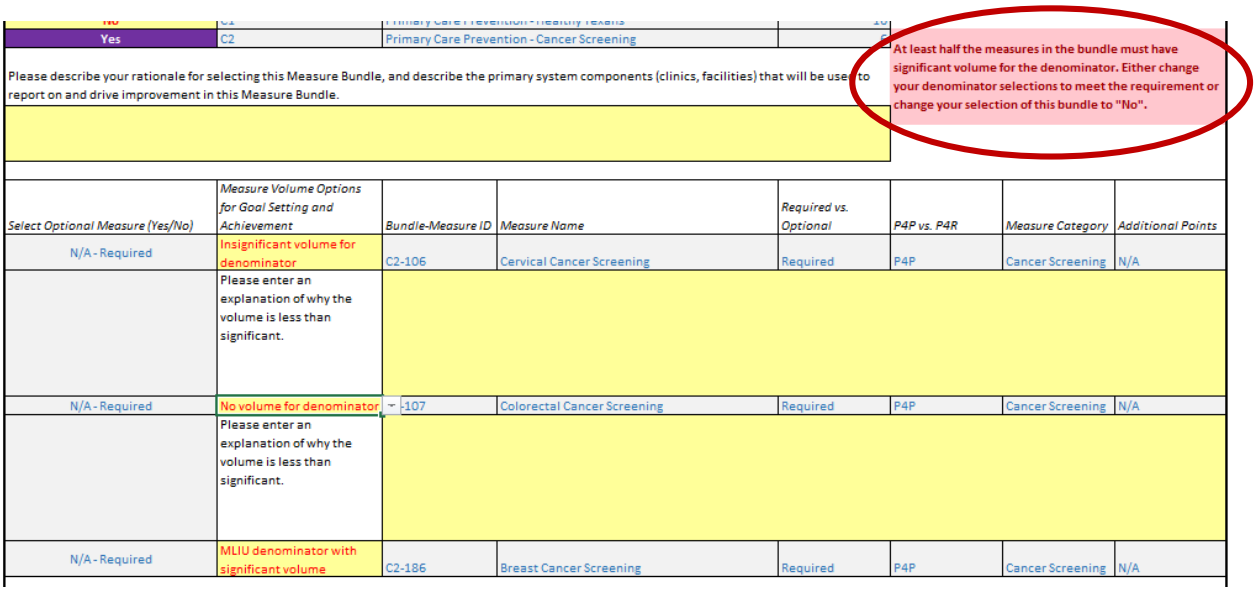
Note that some measures are limited to an all-payer rate or Medicaid-only rate as indicated in the Measure Specifications so the additional dropdown options only include *Insignificant volume for denominator* and *No volume for denominator*.

Select Optional Measure (Yes/No)	*Measure Volume Options for Goal Setting and Achievement*	*Bundle-Measure ID*	*Measure Name*	*Required vs. Optional*	*P4P vs. P4R*	*Measure Category*	*Additional Points*
N/A - Required	Requesting to use all-payer denominator with significant volume	A1-112	Comprehensive Diabetes Care: Foot Exam	Required	P4P	Process	N/A
	Please enter an explanation of why the alternative denominator is being requested.						

For Population based clinical outcomes (PBCOs), the options for measure volume for goal setting and achievement are *MLIU denominator with significant volume, Reporting attributed population as P4P, Requesting to report as P4R,* and *No numerator volume* based on the provider's MPT and the particular PBCO. If *Requesting to report as P4R* or *No numerator volume* is selected, then a justification is required.

N/A - Required	Requesting to report as P4R	A1-500	PQI 93 Diabetes Composite (Adult short-term complications, long-term complications, uncontrolled diabetes, lower-extremity amputation admission rates)	Required	P4P	Population Based Clinical Outcome	N/A
	Please enter an explanation for the PBCO reporting request including estimated numerator and denominator volume and/or justification for no numerator volume						

Note that a Measure Bundle may only be selected if at least half the required measures have significant volume (defined, for most outcome measures, as a denominator for the measurement period that is greater than or equal to 30). If half the measures in the bundle do not meet the volume requirements, then an error message will show and the points for the bundle will not be included in the total points selected. To resolve the error, either change the denominator selections to meet the requirement or change selection of this bundle from *Yes* to *No.*



Step 13J **-** For hospitals and physician practices, the Measure Bundle limitations and requirements include the following and are built into the template functionality:

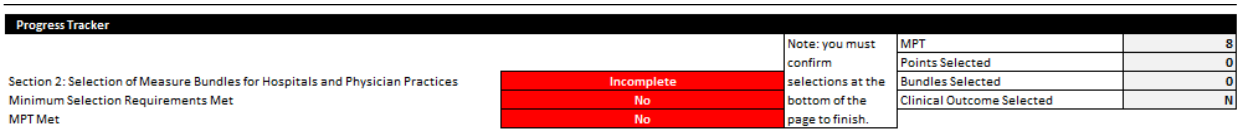
- Measure Bundles K2 Rural Preventive Care and K2 Rural Emergency Care can only be selected by hospitals with a valuation less than or equal to $2,500,000 per DY. Providers that select measure bundle K1 cannot also select measure bundles A1, A2, B1, C1, D1, E1, or H1. Measure K2-285 cannot be selected if measure bundle K1 is selected.
- Each hospital or physician practice with a valuation of more than $2,500,000 per DY must either: 1) select at least one Measure Bundle with at least one required 3 point clinical outcome measure; or 2) select at least one Measure Bundle with at least one optional 3 point clinical outcome measure, and select an optional 3 point measure in that Measure Bundle. Clinical outcomes are identified under “Measure Category”. Three point clinical measures must have significant volume and be P4P to qualify as the required 3 point measure.
- Population Based Clinical Outcome (PBCOs):
    - Each hospital or physician practice with an MPT of 75 must select at least one Measure Bundle with a PBCO.
    - If Measure Bundles A1, A2, B1, C1, D1, and H2, are selected, PBCOs are required for providers with an MPT of 75 and optional as P4P with 4 additional points for providers with an MPT below 75. Providers that do not opt to select a PBCO as

P4P but have a measurable numerator greater than 0 are required to report the PBCO as P4R following the requirements for a measure with insignificant volume.

- For Measure Bundles D4 and D5, the PBCO is a required measure for any provider that selects that Measure Bundle as the PBCO in each bundle is essential to the Measure Bundle objective.

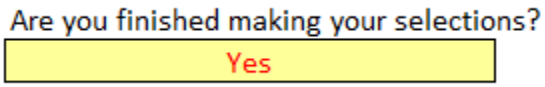
- Measure Bundle I1: Specialty Care requires authorization and may only be selected by hospitals and physician practices with a specialty care project in DY6. Providers will describe their specialty care projects active in DY6 as well as the tool proposed for use in DY7 and DY8, including justification for the tools used in accordance with requirements laid out in the Category C Measure Specifications for measures in the I1 Measure Bundle. HHSC can provide guidance prior to RHP Plan Update submission to providers interested in using instruments that are not on the pre-approved list. Providers may email the waiver mailbox with SUBJECT: Specialty Care Tool. HHSC is developing additional guidance on details to submit with a request.
- If Measure Bundles D3 Pediatric Hospital Safety and J1 Hospital Safety are both selected, the points of each bundle will be reduced by 50%.

The *Progress Tracker* at the top of the *Category C Selection* tab displays whether the requirements are met and the selected points compared to the MPT.



Progress Tracker				
		Note: you must confirm	MPT	8
Section 2: Selection of Measure Bundles for Hospitals and Physician Practices	Incomplete	selections at the	Points Selected	0
Minimum Selection Requirements Met	No	bottom of the	Bundles Selected	0
MPT Met	No	page to finish.	Clinical Outcome Selected	N

Step 14 **-** After you have completed selecting your Measure Bundles/measures, indicate *Yes*.



Step 14A **-** After If you have met or exceeded the MPT, then there is no further action on this tab. If you have not met the MPT, then you will need to confirm your selection. The total valuation will be reduced and displayed as described in PFM paragraph 17.g. and 18.e.

By selecting 'Yes' below, you acknowledge that you have not selected enough measures to meet or exceed your MPT and your valuation will be reduced. You may come back later and change your selections if you would like.

Yes

	Adjusted **DY7-8 DSRIP Valuation Distribution**			
	Valuation if regional private hospital participation requirement is met		Valuation if regional private hospital participation requirement is not met	
	DY7	DY8	DY7	DY8
RHP Plan Update Submission	$900,000.00	$0.00	$900,000.00	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$450,000.00	$450,000.00	$450,000.00	$450,000.00
Category C	$2,475,000.00	$3,375,000.00	$2,925,000.00	$3,825,000.00
Category D	$675,000.00	$675,000.00	$225,000.00	$225,000.00
Total	$4,500,000.00	$4,500,000.00	$4,500,000.00	$4,500,000.00

D. *Category C Additional Details* tab

This tab allows requests for shorter or delayed baseline measurement periods, reporting milestone exemptions, and baseline numerators of zero.

Measures that were indicated on the *Category C Selection* tab as "No volume" will still appear on this tab. Please leave responses as "No" for these measures given that they will be removed from the Measure Bundle.

Measure Exemption Requests

Step 15 **-** The standard baseline measurement period is Calendar Year (CY) 2017. LHD "grandfathered" measures have a standard baseline measurement period of DY6 which cannot be changed. Innovative measures do not have a baseline measurement period so the request is not applicable.

As allowed in PFM paragraph 19.a.i, you may request to use a shorter baseline measurement period of no less than six months for certain measures as indicated in the Measure Specifications. As also allowed in PFM paragraph 19.a.ii, you may request to use a delayed baseline measurement period that ends no later than September 30, 2018.

Providers should report baselines using one of the following scenarios organized in order of HHSC preference:

1. Twelve months of data ending 12/31/17 using electronic or administrative data or sampling.
2. Six months of data ending 12/31/17 using electronic or administrative data or sampling.
3. Baseline numerator of zero (if measure is eligible).
4. Twelve months of approximate data ending 12/31/17.
    a. Approximate baselines are:
        i. Subset of system (data from the DSRIP Performing Provider's system that may not include all elements of the system for baseline).

ii. Clinically similar modifications to required elements of numerator and denominator specifications for baseline only (e.g. foot exam, suicide assessment).

b. Providers requesting to use an approximate baseline should email HHSC a detailed description of the approximate element, its utilization, and how it is approximate to the required measure specification element. HHSC is developing additional guidance on details to submit with a request.

c. HHSC will maintain a record of approvable approximate baseline resolutions in the Category C FAQ, but providers should still seek specific approval from HHSC.

5. Six months of approximate data ending by 12/31/17.
6. Delayed baseline ending by 09/30/2018.

The intent of the order of preference is to ensure meaningful goals and allow providers to begin improvement as early in DY7 as possible.

If requesting a shorter or delayed baseline measurement period, then enter the dates of the shorter or delayed measurement period and an explanation for the request. Providers requesting a delayed baseline should include a description of why other preferred baseline reporting resolutions are not feasible as listed in HHSC preferred order above. Requests for a delayed baseline may result in additional technical assistance or compliance monitoring. Note that an approved delayed baseline results in a change to the DY7 milestone so that achievement may only be earned in PY2 (CY2019).

Bundle-Measure ID	Measure Name			Baseline Measurement Period	Requesting a shorter or delayed measurement period?	Rec
E1-232	Timeliness of Prenatal			CY2017: January 1, 2017 - December 31, 2017	Requesting a shorter baseline measurement period	
Requested Baseline Measurement Period Start Date		Requested Baseline Measurement		Please enter an explanation for this request		

Step 16 **-** In order to be eligible for payment for a P4P measure's reporting milestone, the Performing Provider must report its performance on the all-payer, Medicaid-only, and LIU-only payer types, regardless of requests to use an alternative denominator for goal setting and achievement. This request is different from the denominator request on the *Category C Selection* tab which applied to achievement while this request applies to the reporting milestone. Performing Providers may request to be exempted from reporting a measure's performance for the reporting milestone on the Medicaid-only payer type or the LIU-only payer type with good cause, such as data limitations. Note that reporting a measure's all-payer performance is still required to be eligible for payment for a measure's reporting milestone unless an exception has been noted in the Category C Specifications. For measures that can only be reported as an all-payer rate or Medicaid-only rate as noted in the Category C Specifications, the reporting milestone exemption does not apply (leave response as *No*). For

measures that are innovative measures that are P4R, leave the response as "No" since the P4P reporting milestone does not apply.

Example A of payer-type exceptions:
A small hospital has insignificant volume for a given measure for the combined MLIU rate, but has significant volume for the all-payer rate.

- Achievement milestone exception needed: ***Yes*** - requested use of all-payer rate on ***Category C Selection*** **tab**
- Reporting milestone exception needed: ***No*** - leave response as "No" ***Category C Additional Details*** **tab**

Example B of payer-type exceptions:
An LHD does not gather payer-type information for a selected measure that requires a standard payer-type stratification.

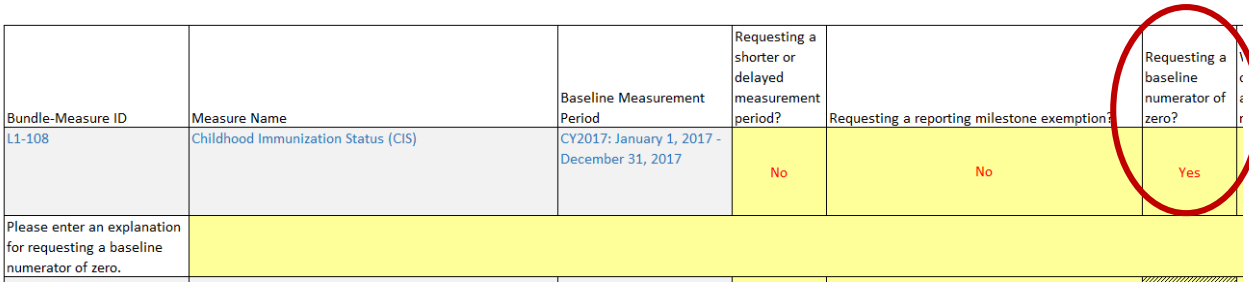
- Achievement milestone exception needed: ***Yes*** - requested use of all-payer rate on ***Category C Selection*** **tab**
- Reporting milestone exception needed: ***Yes*** - requested exemption from reporting on Medicaid-only and LIU-only rate on ***Category C Additional Details*** **tab**

If requesting a reporting milestone exemption, then enter an explanation for the request including a detailed explanation of the good cause need for an exemption.

Bundle-Measure ID	Measure Name	Baseline Measurement Period	Requesting a shorter or delayed measurement period?	Requesting a reporting milestone exemption?
A2-103	Controlling High Blood Pressure	CY2017: January 1, 2017 - December 31, 2017	No	Requesting an exemption from reporting performance on the Medicaid-only payer type
Please enter an explanation for requesting the reporting milestone exemption.				

Step 17 **-** In cases where a Performing Provider has significant denominator volume and no measureable numerator because required numerator inclusions and exclusions were not tracked during the baseline measurement period, a Performing Provider may request to use a baseline numerator of 0 for certain measures designated as process measures and QISMC. This is essentially skipping the baseline collecting period. Measures eligible for a baseline of 0 are indicated in the Category C Measure Specifications.

If requesting to use a baseline numerator of zero, then enter an explanation for the request including a description of steps that have been taken to be able to measure as specified for performance year reporting.



Bundle-Measure ID	Measure Name	Baseline Measurement Period	Requesting a shorter or delayed measurement period?	Requesting a reporting milestone exemption?	Requesting a baseline numerator of zero?
L1-108	Childhood Immunization Status (CIS)	CY2017: January 1, 2017 - December 31, 2017	No	No	Yes
Please enter an explanation for requesting a baseline numerator of zero.					

E. *Category C Valuation* tab

This tab allows updates to the distribution of Category C valuation among Measure Bundles/measures as described in PFM paragraph 17.o. and 18.j. and requires justification for major changes in funding distribution.

Measure Bundle/Measure Valuation

Step 18 **-** Update the distribution of Category C valuation among Measure Bundles/measures to add up to 100 percent based on the minimum and maximum valuation allowed as described in PFM paragraph 17.o. and 18.j. and displayed in the table. Valuation as a percentage of a provider's Category C valuation is applied consistently across DY7-8. Please be sure to include the % symbol in entering any changes.

For hospitals and physician practices, the minimum and maximum allowed are based on:
A = Measure Bundle Point Value
B = The sum of all selected Measure Bundles Point Values
C = Category C valuation

- Minimum Measure Bundle Valuation: *(A/B)*.75 * C*
- Maximum Measure Bundle Valuation for bundles with no P4P clinical or PBCO measure selected: *(A/B) * C*
- Maximum Measure Bundle Valuation for bundles with a P4P selected clinical or PBCO selected: *(A/B)*1.25 *C*

For CMHCs and LHDs, the minimum and maximum allowed are based on:
C = Total Category C Valuation
D = Number of Measures Selected

- Minimum Measure Valuation: *(C/D)*.75*
- Maximum measure valuation for 1-point and 2-point measures: *(C/D)*
- Maximum valuation for a 3 point measures: *(C/D)*1.25*

Note that the template is defaulted to value the Measure Bundles based on the points of the bundle out of the total points selected and measures for CMHCs and LHDs based on the number of measures.

Section 1: Measure Bundle/Measure Valuation

Valuation for Selected Measure Bundles - Hospitals & Physician Practices

						If regional private hospital participation requirement is met		If regional private hospital participation requirement is not met	
Measure Bundle ID	Measure Bundle Name	Points	Desired Valuation Percentage	Minimum Valuation % of Total	Maximum Valuation % of Total	Category C Valuation in DY7	Category C Valuation in DY8	Category C Valuation in DY7	Category C Valuation in DY8
B1	Care Transitions & Hospital Readmissions	11	52.38%	39.28%	65.48%	$532,278.54	$725,834.37	$629,056.46	$822,612.29
C3	Hepatitis C	4	19.05%	14.28%	19.05%	$193,583.55	$263,977.56	$228,780.56	$299,174.57
G1	Palliative Care	6	28.57%	21.42%	28.58%	$290,324.51	$395,897.07	$343,110.78	$448,683.34
Total		21	100.00%	N/A	N/A	$1,016,186.60	$1,385,709.00	$1,200,947.80	$1,570,470.20
Difference between selected percent and 100%:			0.00%						

Step 18A **-** If you have changed the default valuation percentage for a Measure Bundle or measure by more than one percent, then a justification is required (e.g. default is 35.75% and changed to 38%).

Please enter an overall explanation and provide a justification for at least one of the items regarding 1) amount of improvement required for the Measure Bundle(s) or measure(s) with increased valuation including estimated baseline and goals for key measures that may require high amounts of improvement within the bundle or selection; 2) level of effort required for improvement for the Measure Bundle(s) or measure(s) with increased valuation; or 3) size of the population impacted as compared to the size of other selected Measure Bundle(s) or measure(s). Enter NA if one of the items is not applicable.

Explanation of Valuation Percent Changes

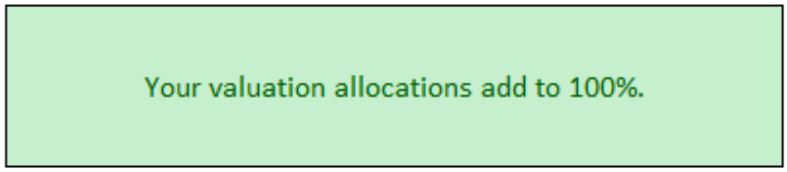
Overall justification for change in Category C valuation distribution.

Please address the amount of improvement required for the Measure Bundle(s) with increased valuation including estimated baseline and goals for key measures that may require high amounts of improvement within the bundle.

Please address the level of effort required for improvement for the Measure Bundle(s) with increased valuation.

Please describe the size of the population impacted as compared to the size of other selected Measure Bundle(s) for the Measure Bundle(s) with increased valuation.

Step 19 **-** If you have completed the allocation of Category C valuation and the allocations add up to 100 percent, then select *Yes.* This data is used to populate the ***IGT Entry Tab.***



Are you finished allocating your Category C valuations across your selected measure bundles?

Yes

F. *Category A Core Activities* tab

This tab requires indication of whether a DY2-6 project was completed in DY2-6 or continuing as a Core Activity in DY7-8. The tab also allows selection of Core Activities.

Transition from DY2-6 Projects to DY7-8 Provider-Level Outcomes and Core Activities

Step 20 **-** For each listed project, indicate if the project was completed in DY2-6 or if it will be continuing as Core Activity. If it is continuing as Core Activity, then you may enter an optional description of the continuation.

"Completed in DY2-6"is used for a) a project that has been cancelled or discontinued, e.g. a clinic has opened but has now been closed or will be closed; or b) all or part of a project will continue, but it will not be considered a Core Activity for DY7-8. "Continuing as a Core Activity in DY7-8" is used for a project that is continuing and will be substantially maintained as Core Activity for DY7-8.

Section 1: Transition from DY2-6 Projects to DY7-8 Provider-Level Outcomes and Core Activities

DY6 Project ID	Project Option	Project Summary	Completed/ Continuing	Enter a description for continuation (optional)
RHP 8_183086102.1.1	1.1.2	Increase the number of Primary Care Physicians (PCPs) which will allow the hospital to increase clinic hours by 5 hours a week.		
RHP 8_183086102.1.2	1.9.2	Increase the access to Specialty Care Physicians (SCPs) by expanding the number of specialty providers and/or increasing clinic hours b y 5 hours per week for the specialists more in demand, with a focus on cancer screening and referral.		

Core Activities

A Core Activity is an activity implemented by a provider to achieve its Category C measure goals. A Core Activity can be an activity implemented by a provider as part of a DY2-6 DSRIP project that the provider chooses to continue in DY7-8, or it can be a new activity that the provider is implementing in DY7-8.

There are certain activities that providers can incorporate in any Core Activity as a sub-activity if it contributes to improving quality of care; such as technology improvements (e.g., Electronic Medical Records or Health Information Exchange connectivity) and continuous quality

improvement (CQI), but the technological advances activities or the CQI should not be the only activity that providers choose to report on.

Each provider needs to select at least one Core Activity that supports the achievement of its Category C measure goals for the selected Measure Bundle(s) or measures. There is no maximum number of Core Activities that a provider may select; however, the provider template limits the selection up to 50.

Providers may select Core Activities from the list created by HHSC and include their own Core Activity by using the *Other* option and providing a description. In addition to selecting Core Activities supporting Category C measures, a provider may include a Core Activity tied to the mission of the provider's organization, even if the activity does not have a strong connection to the selected Measure Bundles or measures. Selection of a Core Activity not tied to the Measure Bundles or measures cannot be the only selection, but can be chosen as an additional Core Activity.

CMS has emphasized the importance of driver diagrams in providers' implementation of DSRIP. The Institute for Healthcare Improvement (IHI) describes a driver diagram as the following:

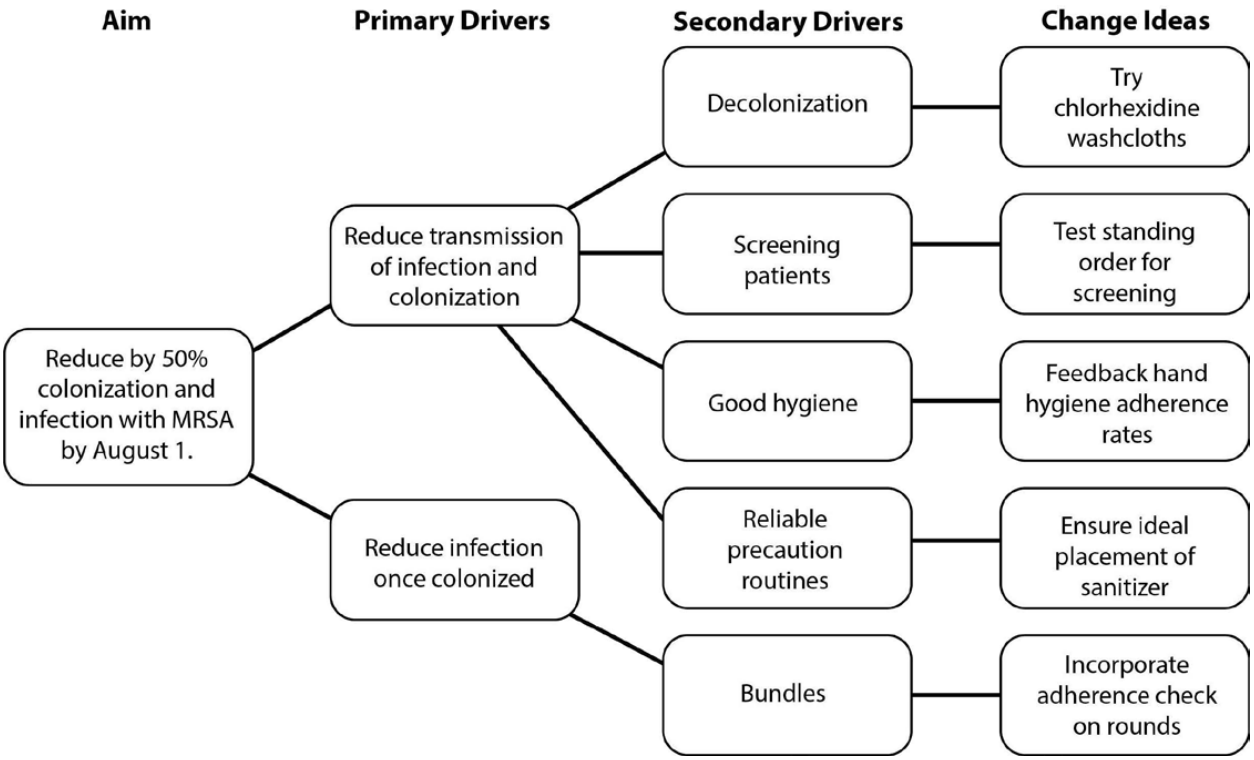
"A driver diagram is a visual display of a team's theory of what "drives," or contributes to, the achievement of a project aim. This clear picture of a team's shared view is a useful tool for communicating to a range of stakeholders where a team is testing and working.

A driver diagram shows the relationship between the overall aim of the project, the primary drivers (sometimes called "key drivers") that contribute directly to achieving the aim, the secondary drivers that are components of the primary drivers, and specific change ideas to test for each secondary driver.

Primary drivers are the most important influencers on the aim, and you will have only a few (we recommend 2 to 5); secondary drivers are influencers on (or natural subsections of) the primary drivers, and you may have many. As you identify each driver, establish a way to measure it."

HHSC considers the "aim" to be each selected Measure Bundle for hospitals and physician practices and each measure for CMHCs and LHDs. The Core Activity is considered the primary driver. Providers will enter the secondary drivers and change ideas in the Provider RHP Plan Update Template and a diagram will be generated in the regional summary file during HHSC review.

Below is IHI's example of a driver diagram:



In DSRIP, the driver diagrams will vary from provider to provider depending on steps each provider chooses to implement since DSRIP offers flexibility for providers to design their initiatives. For example, a DSRIP hospital is selecting Measure Bundle H4: Integrated Care for People with Serious Mental Illness, which corresponds to the "Aim" as shown on the diagram above. This provider will be working on improving physical outcomes for individuals with serious mental illness. The provider's selection of Core Activities shows which primary drivers are utilized, and in this example the provider is selecting the two Core Activities from the grouping of "Availability of Appropriate Levels of Behavioral Health Care Services": *Utilization of Care Management function that integrates primary and behavioral health needs of individuals* and *Provision of services that address social determinants of health and/or family support services*.

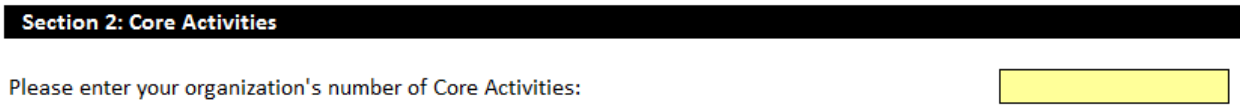
For *Utilization of Care Management function that integrates primary and behavioral health needs of individuals,* the provider can select several secondary drivers, which are components of integrated care. For example, this provider can decide to co-locate primary and behavioral health care providers (as a secondary driver) and make three more exam rooms available for use by new providers (as a change idea). A provider can also decide to utilize one electronic health record (EHR) (as a secondary driver) to increase utilization of available physician health information by behavioral health providers (as a change idea). A provider can implement screening of patients for diabetes (as a secondary driver) with availability of standing orders for such screening (as a change idea). A provider could provide physical exams for individuals with

mental illness (as a secondary driver) and use a flag in the EHR to conduct such an exam (as a change idea).

For the Core Activity *Provision of services that address social determinants of health and/or family support services,* a hospital or physician practice can provide a variety of activities, including but not limited to:

- An assessment of the housing needs for individuals with serious mental illness who cannot provide a physical address as a secondary driver with following the checklist Action Plan that describes steps for determining current housing conditions for such individuals (as a change idea).
- Identification of the patients for a potential home visit in case this patient does not follow medical advice (e.g., medication compliance) as a secondary driver with the identification of lab results that are out of range as a test idea or lack of evidence that this patient purchased prescribed medication (review of the pharmacy data as a change idea).
- Assistance with purchasing of insulin for patients with Type 1 diabetes as a secondary driver with the connection of the patient or his or her family to the coordinator who can connect to available drug purchasing assistance programs (as a change idea).

Step 21 **-** Enter the number of Core Activities planned for DY7-8. The total number should account for projects that the provider indicated would be continued as Core Activities in DY7-8 in Section 1. The maximum number of Core Activities that may be entered is 50.



Step 22 **-** For each Core Activity, select the grouping and name for the Core Activity from the Measure Bundle Protocol or select *Other* and provide a description for *Other.* Do not select the same Core Activity multiple times.

Enter a description for the Core Activity, using a minimum of 150 characters. The description should include estimated number of providers committed to the intervention(s) covered under this Core Activity (e.g. physicians, psychologists, or others who bill for services) and number of locations impacted.

1) Please select the grouping for this Core Activity.

Access to Primary Care Services

a) Please select the name of this Core Activity.

Increase in utilization of mobile clinics

b) Please enter a description of this Core Activity

Step 23 **-** Enter the secondary driver(s) and related change idea(s) to be used to populate a driver diagram in the regional summary. A minimum of one secondary driver and one related change idea is required for each Core Activity. Up to five secondary drivers may be entered per Core Activity and up to five related change ideas for each secondary driver.

i) Please describe the first Secondary Driver for the above Core Activity (required).

Provision of physical exams for individuals with mental illness

A) Please list the first Change Idea for the above Secondary Driver (required).

Step 24 **-** Select the Measure Bundles or measures impacted by the Core Activity or select *None*. Enter a description for how the Core Activities impact the Measure Bundles/measures or explain why no Measure Bundles/measures are impacted.

c) Please select the Measure Bundles or measures impacted by this Core Activity. If this core activity is not associated with any measure bundles or measures, please select "None" in the first dropdown.

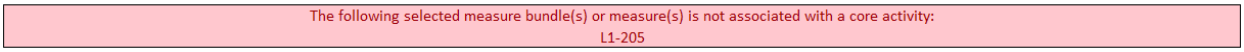
L1-108	L1-347		

i) Please describe how this Core Activity impacts the selected Measure Bundles or measures.

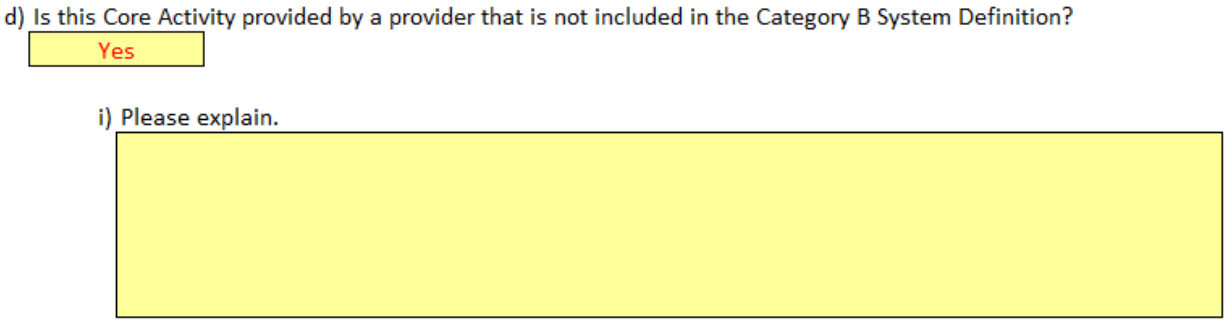
If you selected a Measure Bundle or measure from the dropdown menu in one of the boxes in (c) and later decide not to select any Measure Bundles or measures from the dropdown menu (i.e., to select “None” from the dropdown menu in the first box in (c)) you will need to delete all

of your selections from all of the boxes in (c) before the template will allow you to select "None" from the dropdown menu in the first box.

All selected Measure Bundles or measures must be associated with a Core Activity otherwise an error message will appear at the bottom of Section 2 to indicate which Measure Bundles or measures are not associated with a Core Activity.



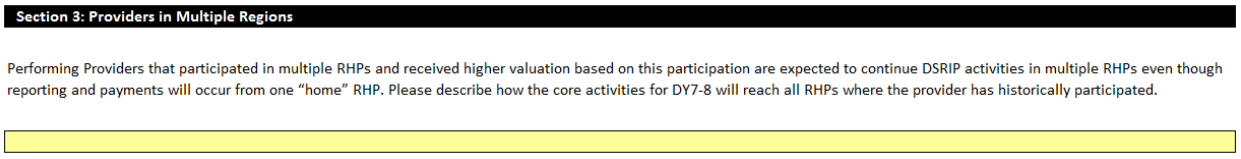
Step 25 **-** If the Core Activity is provided by a provider that is not included in the Category B system definition, then select *Yes* and provide an explanation.



Providers in Multiple Regions

For providers that previously participated in multiple RHPs and received higher valuation based on this participation, HHSC expects DSRIP activities to continue in the multiple RHPs even though reporting and payments will occur from one "home" RHP.

Step 25A **-** Describe how Core Activities will reach all RHPs where the provider has historically participated.



G. *Category D* tab

This tab displays the Statewide Reporting Measure Bundle measures and valuation based on the provider type and requires provider certification of their understanding of Category D.

Statewide Reporting Measure Bundle

The Statewide Reporting Measure Bundle for the provider type is displayed with the measures and valuation. During reporting, providers will be required to submit updates on their activities that are aimed at impacting the measures within the Statewide Reporting Measure Bundle.

Section 1: Statewide Reporting Measure Bundle for Local Health Departments (LHDs)

Measure	Category D valuation distributed across measures (if regional hospital participation requirement is met)	Category D valuation distributed across measures (if regional hospital participation requirement is not met)
Time Since Routine Checkup	$64,285.71	$21,428.57
High Blood Pressure Status	$64,285.71	$21,428.57
Diabetes Status	$64,285.71	$21,428.57
Overweight or Obese	$64,285.71	$21,428.57
Smoker Status	$64,285.71	$21,428.57
Selected Immunizations	$64,285.71	$21,428.57
Prevention of Sexually Transmitted Diseases	$64,285.74	$21,428.58

Step 26A **- Hospitals** may indicate that they do not report the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) as part of the Medicare Inpatient Prospective Payment System due to low volume or other exempt status. If the HCAHPS exemption is being requested, then the rationale, alternative hospital patient satisfaction survey used, and description of the survey must be provided.

Section 1: Statewide Reporting Measure Bundle for Hospitals

Measure	Category D valuation distributed across measures (if regional hospital participation valuation is met)	Category D valuation distributed across measures (if regional hospital participation requirement is not met)
Potentially preventable admissions (PPAs)	$105,000.00	$35,000.00
Potentially Preventable 30-day readmissions (PPRs)	$105,000.00	$35,000.00
Potentially preventable complications (PPCs):	$105,000.00	$35,000.00
Potentially Preventable ED visits (PPVs)	$105,000.00	$35,000.00
Patient satisfaction	$105,000.00	$35,000.00

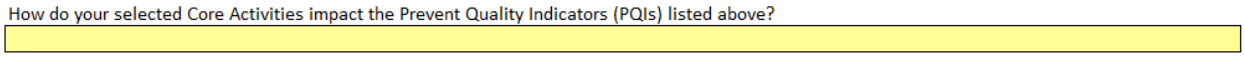
Does your organization not report HCAHPS as part of Medicare Inpatient Prospective Payment System due to low volume or other exempt status?	Yes requesting HCAHPS exemption

Rationale for requesting HCAHPS exemption:

Alternative hospital patient satisfaction survey used:

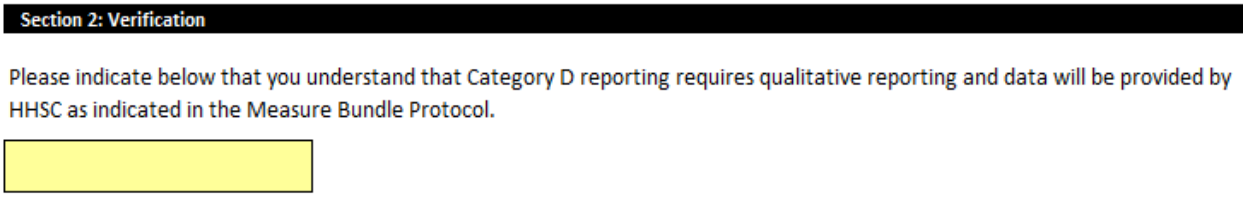
Description of alternative survey:

Step 26A **- Physician practices** are required to explain how their selected Core Activities impact the Prevention Quality Indicators (PQIs) in the Statewide Reporting Measure Bundle.



Verification

Step 26 **-** Enter that you understand Category D data will be provided by HHSC as indicated in the Measure Bundle Protocol.



H. *IGT Entry* tab

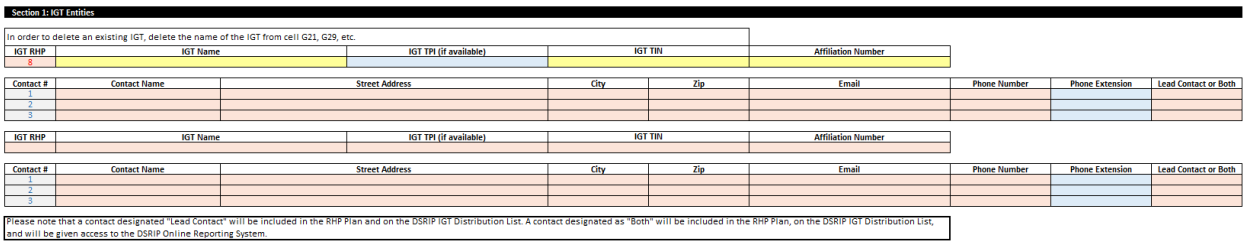
This tab requires confirmation of IGT Entities, updates to percentage distribution of IGT funding, and certification by associated IGT Entities.

IGT Entities

Step 27 **-** IGT Entities and lead contacts are populated based on historical information. Please update the IGT Entities and lead contacts as needed. Entry of a minimum of one IGT Entity is required. A maximum of eight IGT Entities may be entered.

Please note that a contact designated "Lead Contact" will be included in the RHP Plan and on the DSRIP Provider Distribution List. A contact designated as "Both" will be included in the RHP Plan, on the DSRIP Provider Distribution List, and will be given access to the DSRIP Online Reporting System.

Note that if you double-click on a cell, the contents will be erased due to formulas used to populate the field.



IGT Funding

Step 28 **-** Update the percentage distribution of IGT funding across the Categories and measures. If a historical IGT Entity is used, then the percentage is pre-populated based on the proportion of DSRIP funded in DY6. If a new IGT Entity is added, then the percentage defaults to zero percent.

Note that the IGT amounts displayed are only estimates based on the selections within the template. Actual IGT due will be based on HHSC approval of Measure Bundle/measure selections, requested Category C exemptions, and submitted reporting as well as FMAP applied at payment processing.

Section 2: IGT Funding

						If regional private hospital participation requirement is met		If regional private hospital participation requirement is not met	
	IGT Name	IGT TIN	IGT Affiliation #	DY7 % IGT Allocated	DY8 % IGT Allocated	Total Estimated DY7 Allocation (FMAP 56.88/IGT 43.12)	Total Estimated DY8 Allocation (FMAP 57.32/IGT 42.68)	Total Estimated DY7 Allocation (FMAP 56.88/IGT 43.12)	Total Estimated DY8 Allocation (FMAP 57.32/IGT 42.68)
RHP Plan Update Submission	Paris Lamar County Health Department	17560022067001	100-13-0000-00062	100.00%		$32,340.00		$32,340.00	
Category B	Paris Lamar County Health Department	17560022067001	100-13-0000-00062	100.00%	100.00%	$16,170.00	$16,005.00	$16,170.00	$16,005.00
L1-205	Paris Lamar County Health Department	17560022067001	100-13-0000-00062	100.00%	100.00%	$88,935.00	$120,037.50	$105,105.00	$136,042.50
L1-242	Paris Lamar County Health Department	17560022067001	100-13-0000-00062	100.00%	100.00%	$88,935.00	$120,037.50	$105,105.00	$136,042.50
L1-344	Paris Lamar County Health Department	17560022067001	100-13-0000-00062	100.00%	100.00%	$88,935.00	$120,037.50	$105,105.00	$136,042.50
Category D	Paris Lamar County Health Department	17560022067001	100-13-0000-00062	100.00%	100.00%	$24,255.00	$24,007.50	$8,085.00	$8,002.50

The template notes whether the funding per item adds to 100%.

Your funding allocations sum to 100%.

Certification

Step 29 **-** For each IGT Entity, enter the name of the person and date for who is certifying the IGT amounts listed under IGT funding. A provider or RHP anchor may obtain written certification from the IGT Entity, and the provider may complete this section on the IGT Entity's behalf. The separate documentation received does not need to be submitted with the RHP Plan Update Template, but must be maintained for recordkeeping and audit purposes.

Note that changes in IGT will continue to be allowed during each reporting period and if sufficient IGT is not submitted, then providers associated with the IGT Entity will be proportionately paid.

Section 3: Certification

By my signature below, I certify the following facts:

- I am legally authorized to sign this document on behalf of my organization;
- I have read and understand this document:

Name:	
IGT Organization:	Paris Lamar County Health Department
Date:	

I. *Summary and Certification* tab

This tab summarizes the selection in previous tabs and requires certification of the selections. Note that this tab is not an indicator of completeness from the other tabs. Please use the individual tabs and *Overall Template Progress* tab to determine if a tab is complete.

DY7-8 DSRIP Valuation

Step 30 **-** Confirm the valuation information and the understanding of limited changes.

Section 1: DY7-8 DSRIP Valuation

	DY7-8 DSRIP Valuation Distribution			
	Valuation if regional private hospital participation requirement is met		Valuation if regional private hospital participation requirement is not met	
	DY7	DY8	DY7	DY8
RHP Plan Update Submission	$100,000.00	$0.00	$100,000.00	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$50,000.00	$50,000.00	$50,000.00	$50,000.00
Category C	$275,000.00	$375,000.00	$325,000.00	$425,000.00
Category D	$75,000.00	$75,000.00	$25,000.00	$25,000.00
Total	$500,000.00	$500,000.00	$500,000.00	$500,000.00

Do you confirm the information in this section and acknowledge the understanding of limited allowed changes as described in the Program Funding and Mechanics Protocol and Measure Bundle Protocol?

Yes

Category B MLIU PPP

Step 31 **-** Confirm the MLIU PPP information and the understanding of limited changes.

Section 2: Category B Medicaid Low-income Uninsured (MLIU) Patient Population by Provider (PPP)

	MLIU PPP	Total PPP	MLIU Percentage of Total PPP
DY5	5200	6500	80%
DY6	5700	6600	86%
DY7 Estimated	5450	6550	83%
DY8 Estimated	5450	6550	83%

Were DY7-8 maintenance goals based on DY5 or DY6 only?	No

Do you confirm the information in this section and acknowledge the understanding of limited allowed changes as described in the Program Funding and Mechanics Protocol and Measure Bundle Protocol?

Yes

Category C Measure Bundles/Measures Selection and Valuation

Step 32 **-** Confirm the Measure Bundles/measures information and the understanding of limited changes.

						Valuation if regional private hospital participation		Valuation if regional private hospital participation	
Bundle-Measure ID	Measure Bundle/Measure Name	# of Measures with Requested Achievement of Alternative Denominators	# of Measures with Requested Shorter or Delayed Measurement	# of Measures with Requested Reporting Milestone Exemptions	Points	DY7 Valuation	DY8 Valuation	DY7 Valuation	DY8 Valuation
C2	Primary Care Prevention - Cancer Screening & Follow Up	0	0	1	6	$55,000.00	$75,000.00	$65,000.00	$85,000.00
H1	Integration of Behavioral Health in a Primary or Specialty Care Setting	0	1	0	8	$192,500.00	$262,500.00	$227,500.00	$297,500.00
H4	Integrated Care for People with Serious Mental Illness	0	0	0	3	$27,500.00	$37,500.00	$32,500.00	$42,500.00
Total	N/A	0	1	1	17	$275,000.00	$375,000.00	$325,000.00	$425,000.00

Do you confirm the information in this section and acknowledge the understanding of limited allowed changes as described in the Program Funding and Mechanics Protocol and Measure Bundle Protocol?
Yes

Category A Core Activities Associated with Category C Measure Bundles/Measures

Step 33 **-** Confirm the Core Activities associated with Measure Bundles/measures information and the understanding of limited changes.

Section 4: Category A Core Activities Associated with Category C Measure Bundles/Measures

Bundle-Measure ID	Measure Bundle/Measure Name	Associated Core Activities
C2	Primary Care Prevention - Cancer Screening & Follow Up	Enhancement in data exchange between hospitals and affiliated medical home sites.
H1	Integration of Behavioral Health in a Primary or Specialty Care	Enhancement in data exchange between hospitals and affiliated medical home sites.
H4	Integrated Care for People with Serious Mental Illness	Enhancement in data exchange between hospitals and affiliated medical home sites.
	Unassociated Core Activities	Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (e.g., Technology Supported Multi Component Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss; Coordinated Approach to Child Health - CATCH; and SPARK among others)

Do you confirm the information in this section and acknowledge the understanding of limited allowed changes as described in the Program Funding and Mechanics Protocol and Measure Bundle Protocol?
Yes

Category D Valuation

Step 34 **-** Confirm the Category D information and the understanding of limited changes.

Section 5: Category D Valuations

Statewide Reporting for Hospitals and Physicians Practices

Measure	Category D valuation distributed across measures (if regional hospital participation requirement is met)	Category D valuation distributed across measures (if regional hospital participation requirement is not met)
Diabetes Short-term Complications Admission Rate	$5,769.23	$1,923.08
Perforated Appendix Admission Rate	$5,769.23	$1,923.08
Diabetes Long-term Complications Admission Rate	$5,769.23	$1,923.08
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	$5,769.23	$1,923.08
Hypertension Admission Rate	$5,769.23	$1,923.08
Heart Failure Admission Rate	$5,769.23	$1,923.08
Low Birth Weight Rate	$5,769.23	$1,923.08
Dehydration Admission Rate	$5,769.23	$1,923.08
Bacterial Pneumonia Admission Rate	$5,769.23	$1,923.08
Urinary Tract Infection Admission Rate	$5,769.23	$1,923.08
Uncontrolled Diabetes Admission Rate	$5,769.23	$1,923.08
Asthma in Younger Adults Admission Rate	$5,769.23	$1,923.08
Lower-Extremity Amputation among Patients with Diabetes Rate	$5,769.24	$1,923.04

Do you confirm the information in this section and acknowledge the understanding of limited allowed changes as described in the Program Funding and Mechanics Protocol and Measure Bundle Protocol?
Yes

Certification

Step 35 **-** Enter the name of the person, the name of the organization, and the date for who is certifying to the information included in the provider template.

Section 6: Certification

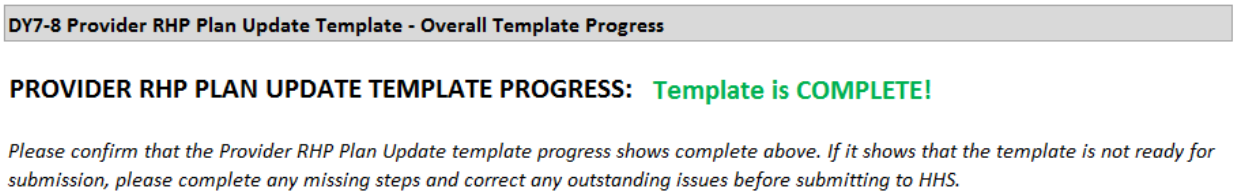
By my signature below, I certify the following facts:
- I am legally authorized to sign this document on behalf of my organization;
- I have read and understand this document:
- The statements on this form regarding my organization are true, correct, and complete to the best of my knowledge and belief.

Name:	
Performing Provider:	
Date:	

J. *Overall Template Progress* tab

This tab summarizes the completion of items from each tab to determine if the full template is complete.

Step 36 **-** Review if any items show as *Incomplete* and resolve the issue. Once the template shows as *Template is COMPLETE,* then the file is ready for submission to your Anchor.



Step 37 **-** Once the template is ready for submission to your Anchor, save the file with a name that includes the RHP and the TPI used in the template, with no spaces: “RHP_XX_123456789”. Follow the steps to submit the template to your Anchor as directed by your Anchor.

DY7-8 RHP Plan Update - Anchor Template

Each Anchor must complete a *RHP Plan Update Anchor Template* and compile provider templates.

The Anchor template includes the following tabs:

- *Inputs* tab - requires compilation of provider templates to check whether the private hospital participation requirement has been met and summarize provider entries.
- *Anchor Entry* tab - allows updates to Anchor Lead Contacts.
- *RHP Organization* tab - populates the DSRIP Performing Provider and DSRIP IGT Entity contact information from the provider templates; requires entry of UC-only hospital and UC-only IGT Entity contact information; and allows entry of collaborating organization contact information.
- *Community Needs Assessment* tab - requires entry of process and updates to the regional community needs assessment.
- *Stakeholder Engagement* tab - requires description of the extension stakeholder forum and ongoing public engagement.
- *Learning Collaborative Plan* tab - requires description of the DY7-8 learning collaborative plan as required in the PFM.
- *Regions with Additional Funds* tab, if applicable - requires description of the process used to allocate additional funds among regional providers.
- *Regional Valuation* tab - verifies whether the regional private hospital participation requirement is met and provides a summary of Performing Providers' valuation based on meeting the requirement as populated from the provider templates.
- *Regional Category B* tab - provides a summary of Performing Providers' system components and MLIU PPP as populated from the provider templates.
- *Regional Category C Summary* tab - provides a summary of Performing Providers' selected Measure Bundles/measures, exemption requests, and points selected.
- *Overall Template Progress* tab - summarizes the completion of items from each tab that requires entry to determine if the full template is complete.

Technical notes regarding the template:

- Note that the tabs requiring Anchor entry may be completed prior to compiling the provider templates.
- To ensure the template works properly, please be sure to click the *Enable Macros* button if it pops up upon opening the file. Also, confirm that workbook calculations are set to *Automatic.* (Under the *File* tab in Excel, click *Options*, followed by *Formulas*. Under *Calculation Options*, select *Automatic for Workbook Calculation*. Or under the *Formulas* tab, click on *Calculation Options* and select *Automatic*.)
- If there are pop-ups to *Enable Editing, Enable Content,* or *Do you want to make this a trusted document***,** select to enable/allow for the template to function properly.
- If you would like to copy and paste text from another document, please double click in the cell you are trying to paste into before pasting.

- Please note that it may take one or two seconds for the template to calculate after making an entry. If an error occurs, please try to redo the most recent action and wait a few seconds.
- Please allow time to compile provider templates given that the templates will be large and it may be a slow process to pull in the data.
- If you would like to print pages, then go to *Page Layout* → *Page Setup*, and change the scaling and/or the orientation to fit according to your needs.

If you encounter problems with the template, please contact the waiver mailbox at TXHealthcareTransformation@hhsc.state.tx.us with SUBJECT: RHP Plan Update Template.

Step-by Step Instructions for Completing the Anchor Template

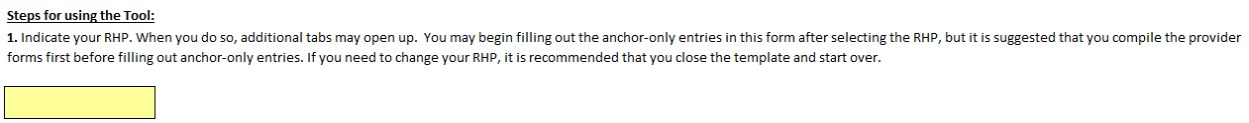
The format of the cells in the template correspond to the following:

Input cell (required)
Pre-populated (Anchor CANNOT edit)
Pre-populated (but Anchor CAN edit)
Optional

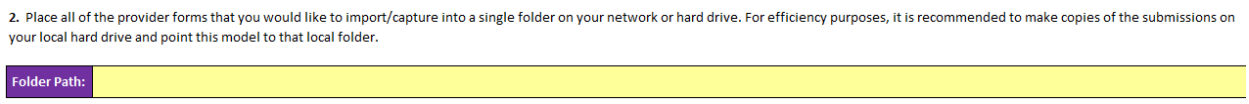
A. *Inputs* tab

This tab requires identification of your RHP and compilation of provider templates.

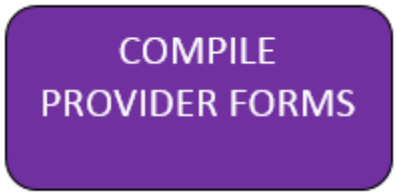
Step 1 **-** Select your RHP. This will open up the tabs that require Anchor entry.



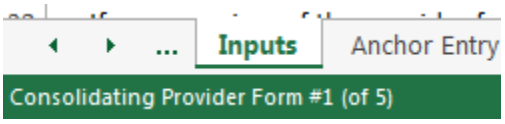
Step 2 **-** If you have received all the provider templates, then save them in one folder and paste the link.



Step 3 **-** Run the consolidation by clicking the "Compile Provider Forms" button.



At the bottom left-hand corner, the progress will be displayed. Note that it may take some time for the templates to be compiled.



A table with the status of each file will be shown to indicate if the file was compiled, did not appear to be a provider form, appeared to be a duplicate form, or if the provider chose to withdraw.

Successfully Compiled Provider Form(s)*	5	Non Provider Form(s)	0
*All successfully compiled provider forms appear to be in the correct RHP (based on selection above)		Duplicate Provider Form(s)	0
		Provider(s) Withdrawing from DSRIP	0
Total	5		

Name of files in folder path:	RHP	TPI	Comment
RHP_18_084001901.xlsm	18	084001901	Successfully compiled
RHP_18_084434201.xlsm	18	084434201	Successfully compiled
RHP_18_111111111.xlsm	18	111111111	Successfully compiled
RHP_18_169553801.xlsm	18	169553801	Successfully compiled
RHP_18_194997601.xlsm	18	194997601	Successfully compiled

B. *Anchor Entry* tab

This tab allows updates to Anchor Lead Contacts.

Step 4 **-** The lead contacts (up to three) are populated based on historical information. Please update the contacts as needed. Please note that a contact designated "Lead Contact" will be included in the RHP Plan and on the DSRIP Provider Distribution List. A contact designated as "Both" will be included in the RHP Plan, on the DSRIP Provider Distribution List, and will be given access to the DSRIP Online Reporting System.

Note that if you double-click on a cell, the contents will be erased due to formulas used to populate the field.

Section 2: Contact Information

Lead Contact #1	
Contact Name:	
Street Address:	
City:	
Zip Code:	
Email:	
Phone Number:	
Phone Ext:	
Lead Contact or Bot	
Lead Contact #2	
Contact Name:	
Street Address:	
City:	
Zip Code:	
Email:	
Phone Number:	
Phone Ext:	
Lead Contact or Bot	
Lead Contact #3	
Contact Name:	
Street Address:	
City:	
Zip Code:	
Email:	
Phone Number:	
Phone Ext:	
Lead Contact or Bot	

C. *RHP Organization* tab

This tab populates the DSRIP Performing Provider and DSRIP IGT Entity contact information from the provider templates; requires entry of UC-only hospital and UC-only IGT Entity contact information; and allows entry of collaborating organization contact information.

The contact information for DSRIP Performing Providers is populated in Section 1.

Section 1: DSRIP Performing Providers

DSRIP Performing Provider 1

RHP	TPI	Name	Performing Provider Type	Ownership	TIN	Lead Contact(s)	
18	084001901	Collin County MHMR dba LifePath Systems	Community Mental Health Center (CMHC)	Non-State Owned Public	17423795305002	1	Randy R
	Filename	CMHC				2	Tammy
						3	

DSRIP Performing Provider 2

RHP	TPI	Name	Performing Provider Type	Ownership	TIN	Lead Contact(s)	
18	084434201	MHMR SVCS of Texoma	Center (CMHC)	Non-State Owned Public	17423795305002	1	Sylvia Ca
	Filename	CMHC 2				2	Jewel M
						3	Michael

DSRIP Performing Provider 3

RHP	TPI	Name	Performing Provider Type	Ownership	TIN	Lead Contact(s)	
18	169553801	Tenet Frisco Ltd dba Centennial Medical Center	Hospital	Private	17423795305002	1	Blaise B
	Filename	Hospital				2	
						3	

The contact information for DSRIP IGT Entities is populated in Section 2.

Section 2: DSRIP IGT Entities

DSRIP IGT Entity 1

RHP	IGT TPI (if available)	IGT Name	TIN	Lead Contact(s)	
18	N/A	Collin County MHMR dba LifePath Systems	17517619114003	1	Randy
				2	
				3	

DSRIP IGT Entity 2

RHP	IGT TPI (if available)	IGT Name	TIN	Lead Contact(s)	
18		IGT Entity	12345678978945	1	Conta
				2	
				3	

DSRIP IGT Entity 3

RHP	IGT TPI (if available)	IGT Name	TIN	Lead Contact(s)	
18	N/A	MHMR Services of Texoma	17514523608014	1	Sylvia
				2	
				3	

UC-Only Hospitals

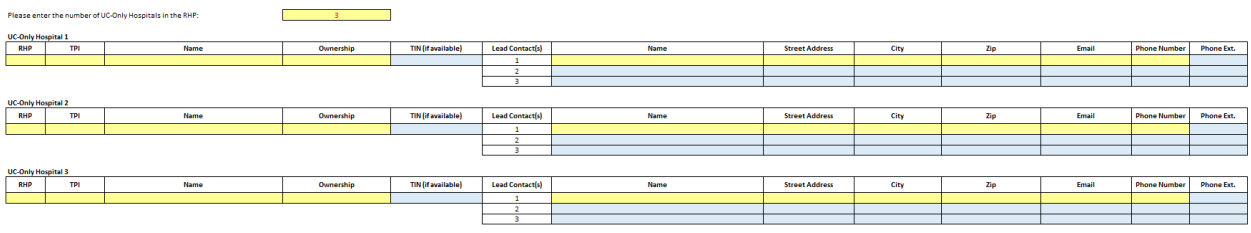
Step 5 **-** Enter the number of UC-only hospitals that are participating in your region.

Section 3: UC-Only Hospitals (Anchor Entry)

Please enter the number of UC-Only Hospitals in the RHP:

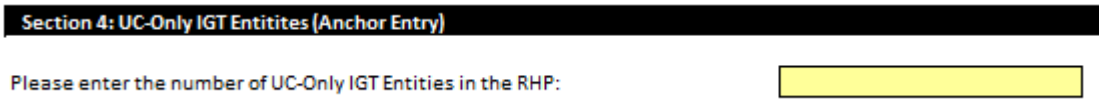
Step 6 **-** Based on the number entered, the corresponding number of entries opens up. Please enter the lead contacts (up to three) for each UC-only hospital. Please note that a contact designated "Lead Contact" will be included in the RHP Plan and on the DSRIP Provider Distribution List. A contact designated as "Both" will be included in the RHP Plan, on the DSRIP Provider Distribution List, and will be given access to the DSRIP Online Reporting System.

Note that if you double-click on a cell, the contents will be erased due to formulas used to populate the field.



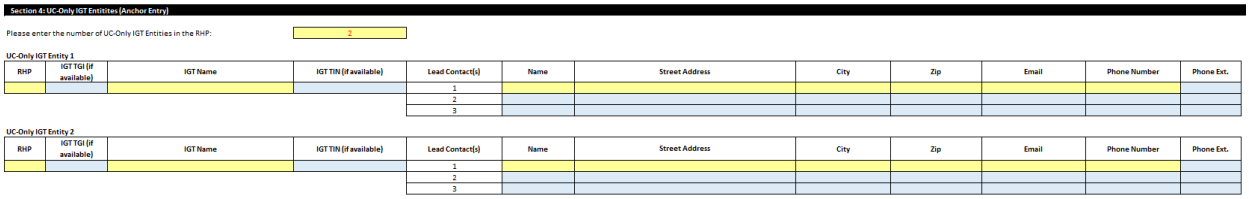
UC-Only IGT Entities

Step 7 **-** Enter the number of UC-only IGT Entities that are participating in your region.



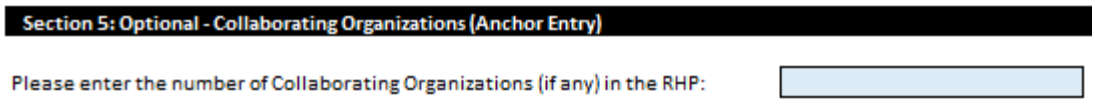
Step 8 **-** Based on the number entered, the corresponding number of entries opens up. Please enter the lead contacts (up to three) for each UC-only IGT Entity. Please note that a contact designated "Lead Contact" will be included in the RHP Plan and on the DSRIP Provider Distribution List. A contact designated as "Both" will be included in the RHP Plan, on the DSRIP Provider Distribution List, and will be given access to the DSRIP Online Reporting System.

Note that if you double-click on a cell, the contents will be erased due to formulas used to populate the field.



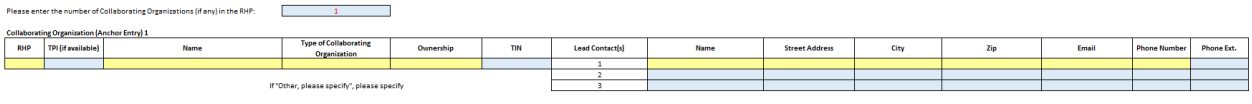
Collaborating Organizations *(Optional)*

Step 9 **-** If you have organizations that participated in the RHP Plan Update process or through stakeholder engagement that you would like to include, then enter the number of collaborating organizations.



Step 10 **-** Based on the number entered, the corresponding number of entries opens up. Please enter the type of collaborating organization (physician practice, CMHC, MCO, FQHC, Other) and the lead contacts (up to three) for each collaborating organization. Please note that a contact designated "Lead Contact" will be included in the RHP Plan and on the DSRIP Provider Distribution List. A contact designated as "Both" will be included in the RHP Plan, on the DSRIP Provider Distribution List, and will be given access to the DSRIP Online Reporting System.

Note that if you double-click on a cell, the contents will be erased due to formulas used to populate the field.



D. *Community Needs Assessment* tab

This tab requires entry of process and updates to the regional community needs assessment. A separate, updated community needs assessment may be submitted in addition to responding to the questions in this tab, but it is not required.

Step 11 **-** Respond to the four questions regarding updating the Community Needs Assessment. Enter the information in the first cell for each question and use the additional cells as needed. Excel has limited row height expansion to 26 lines.

1. Describe the RHP's process for updating the regional community needs assessment.
   This section should include:
   - A summary of the region's process for updating the RHP community needs assessment;
   - Major activities conducted by the RHP during this process;
   - Data sources or resources/consultants used; and
   - Any other information that the Anchor thinks is important to provide.

2. Describe the RHP's process for soliciting community stakeholder input on the community needs assessment.
   This section should describe the process used to obtain stakeholder feedback on the community needs assessment, which stakeholder groups/types were involved (e.g. local physician groups), including stakeholders who are not currently performing providers in the region.

3. Describe the RHP's community needs that changed or the priorities that were updated, if any, as a result of this process.
   This section should describe the new community needs/priorities and how they changed from the original community needs assessment submitted with the original RHP Plan in 2012. If the updated community needs assessment did not result in new community priorities, this should be explained.

4. Any additional information the Anchor would like to share about the RHP's updated community needs assessment.

E. *Stakeholder Engagement* tab

This tab requires description of the extension stakeholder forum and ongoing public engagement.

Extension Stakeholder Engagement Forum

Step 12 **-** Respond to the three questions regarding the extension stakeholder forum. If the forum will be held after RHP Plan Update submission, then please explain how these items will be addressed. Enter the information in the first cell for each question and use the additional cells as needed. Excel has limited row height expansion to 26 lines.

Section 1: Extension Stakeholder Engagement
As specified in the Program Funding and Mechanics Protocol (PFM), once CMS and HHSC agree on the longer term extension, the Anchoring Entity must conduct an extension stakeholder engagement forum to promote collaboration in the next phase of the waiver and community goals. The RHP Plan Update or a summary must be posted on the RHP's website prior to the forum or collecting stakeholder feedback.
1. Describe the extension stakeholder engagement forum, including the date, location, agenda items, and participants. If the forum is scheduled to occur after RHP Plan Update submission, then please explain.
2. Describe how stakeholder input was gathered and informed the RHP Plan Update (e.g. email submission of public comments, responses during forum).
3. Describe how feedback from the forum or the stakeholder input process was used to inform the learning collaborative plan for I

General Stakeholder Engagement

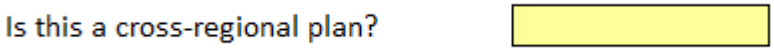
Step 13 **-** Respond to the two questions regarding ongoing public engagement. Enter the information in the first cell for each question and use the additional cells as needed. Excel has limited row height expansion to 26 lines.

Section 2: General Stakeholder Engagement
4. Describe plans for ongoing public engagement in DY7-8 (e.g. quarterly public meetings, newsletters, annual surveys).
5. Describe any additional information the Anchor would like to share about the RHP's stakeholder engagement.

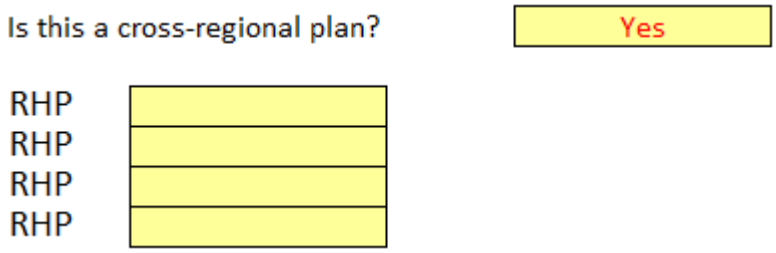
F. *Learning Collaborative Plan* tab

This tab requires description of the DY7-8 learning collaborative plan as required in the PFM.

Step 14 **-** Indicate whether the DY7-8 learning collaborative plan is a cross-regional plan and the remaining questions will open up.



Step 14A **-** If it is a cross-regional plan, then enter the participating RHPs.



Step 15 **-** Respond to the seven questions regarding the DY7-8 learning collaborative plan. Enter the information in the first cell for each question and use the additional cells as needed. Excel has limited row height expansion to 26 lines.

1. Describe the topics for each learning collaborative you plan to conduct in DY7-8. Please note planned dates and locations, if known.

2. Describe the goals of each learning collaborative that you plan to conduct in DY7-8 and how they will be achieved. The anchor must conduct at least one learning collaborative that includes a focus on DSRIP integration into Medicaid managed care, value-based purchasing, alternative payment models, or sustainability strategies for low-income uninsured.

3. Describe the key design elements for improvement design (such as Institute for Healthcare Improvement (IHI) Model for Improvement; Plan, Do, Study, Act (PDSA), etc.)

4. Describe learning collaborative participant involvement, including any plans to include cross regional participants, or individuals/organizations who are not DSRIP performing providers, such as community partners or managed care organizations. Describe the

5. Describe the learning system design (how to share information and data, including Category C outcome

6. Describe learning collaborative format and frequency (meetings, workgroups, webinars / quarterly, monthly, etc). Indicate if web access to the learning collaboratives will be available.

7. Please include any additional information you would like to share about your plan.

Step 15A - If multiple regions are submitting a cross-regional plan, please copy and paste the same information for all participating RHPs and respond to the additional two questions regarding cross-regional participation. Enter the information in the first cell for each question and use the additional cells as needed. Excel has limited row height expansion to 26 lines.

8. Describe leadership structure among participating regions.

9. Describe how your learning collaborative goals will address the needs and providers of all participating regions.

G. *Regions with Additional Funds* tab

If applicable, this tab requires description of the process used to allocate additional funds among regional providers.

Step 16A - Provide the information for the two required stakeholder meetings.

Section 1: Stakeholder Meetings

As specified in the Program Funding and Mechanics Protocol (PFM), each RHP must conduct at least two public stakeholder meetings to determine the uses for the additional funding.

1. List the two stakeholder meetings

	Date	Time	Location	# of Participants	Description
Meeting #1					
Meeting #2					

Step 16B - Respond to the four questions describing the process for allocating additional funds. Enter the information in the first cell for each question and use the additional cells as needed. Excel has limited row height expansion to 26 lines.

Section 2: Process for Allocating Additional Funds

2. Describe the process to determine the uses for the additional funding, including identifying new providers and applying the community needs assessment.

3. Describe how the additional funds were allocated among Performing Providers and any new providers.

4. Indicate providers that expressed interest in additional funds but were not allocated any additional funds, including provider name, type (e.g. private physician practice, public hospital), and reason why they were not allocated additional funds.

5. Describe any additional information the Anchor would like to share about allocating the additional funds.

H. *Regional Valuation* tab

This tab verifies whether the regional private hospital participation requirement is met and provides a summary of Performing Providers' valuation based on meeting the requirement as populated from the provider templates.

The Section 1 table displays whether the regional private hospital participation requirement is or is not met and displays the corresponding valuation by provider, Category, and DY. Each row represents one provider.

Section 1: Private Hospital Participation Valuation

Required Regional Amount	Total Private Hospital Valuation	Requirement Met?
$5,151,709.00	$6,111,039.99	Yes

DSRIP Performing Providers:

					DY7 Valuation Category					
RHP	TPI	Performing Provider Name	Performing Provider Type	Ownership	RHP Plan Update Submission	Category A	Category B	Category C	Category D	Total DY7
18	084001901	Collin County MHMR dba LifePath Systems	Community Mental Health	Non-State Owned Public	$2,498,828.80	$0.00	$1,249,414.40	$6,871,779.20	$1,874,121.60	$12,494,144.00
18	084434201	MHMR SVCS of Texoma	Community Mental Health	Non-State Owned Public	$844,781.40	$0.00	$422,390.70	$2,323,148.85	$633,586.05	$4,223,907.00
18	111111111	Hospital A	Hospital	Non-State Owned Public	$63,657.20	$0.00	$31,828.60	$175,057.30	$47,742.90	$318,286.00
18	169553801	Tenet Frisco Ltd dba Centennial Medical Center	Hospital	Private	$222,208.00	$0.00	$111,104.00	$611,071.99	$166,656.00	$1,111,039.99
18	194997601	UHS Texoma, Inc. dba Texoma Medical Center	Hospital	Private	$1,000,000.00	$0.00	$500,000.00	$2,750,000.00	$750,000.00	$5,000,000.00

Region with Additional Funding: Exceeded Total?	No

The Section 2 table displays a summary of the regional valuation by provider type and Category.

Section 2: Regional Valuation

By Performing Provider Type

Performing Provider Type	DY7 Valuation	DY8 Valuation	Total Valuation
Hospitals	$4,311,039.99	$4,311,039.99	$8,622,079.98
Private Hospitals	$4,311,039.99	$4,311,039.99	$8,622,079.98
Non-state Owned and State Owned Public Hospitals	$0.00	$0.00	$0.00
Physician Practices	$500,000.00	$500,000.00	$1,000,000.00
CMHCs	$16,794,144.00	$16,794,144.00	$33,588,288.00
LHDs	$0.00	$0.00	$0.00
TOTAL	$21,605,183.99	$21,605,183.99	$43,210,367.98

By Category

Category	DY7 Valuation	DY8 Valuation	Total Valuation
RHP Plan Update Submission	$4,321,036.80	$0.00	$4,321,036.80
Category A	$0.00	$0.00	$0.00
Category B	$2,160,518.40	$2,160,518.40	$4,321,036.80
Category C	$14,043,369.59	$18,364,406.39	$32,407,775.98
Category D	$1,080,259.20	$1,080,259.20	$2,160,518.40
TOTAL	$21,605,183.99	$21,605,183.99	$43,210,367.98

I. *Regional Category B* tab

This tab provides a summary of Performing Providers' system components and MLIU PPP as populated from the provider templates by provider type.

The Section 1 table displays a "Y" for the system components selected by each provider. Each row represents one provider. The tables are divided by provider type.

Section 1: System Components

Hospitals:

			Required System Components					Optional System Components					
RHP	TPI	Performing Provider Name	Inpatient Services	Emergency Department	Owned or Operated Outpatient Clinics	Maternal Department	Owned or Operated Urgent Care Clinics	Contracted Specialty Clinics	Contracted Primary Care Clinics	School-based Clinics	Contracted Palliative Care Programs	Contracted Mobile Health Programs	Other
18	169553801	Tenet Frisco Ltd dba Centennial Medical Center	Y		Y		Y		Y				Y
18	194997601	UHS Texoma, Inc. dba Texoma Medical Center	Y	Y	Y	Y					Y		

Physician Practices:

			Required System Components					Optional System Components		
RHP	TPI	Performing Provider Name	Owned or Operated Primary Clinics	Owned or Operated Specialty Care Clinics	Owned or Operated Hospital	Owned or Operated Urgent Care Clinics	Contracted Specialty Clinics	Contracted Primary Care Clinics	Contracted Community-based Programs	Other
18	888888888	Provider A			Y	Y			Y	

The Section 2 table displays the MLIU PPP and Total PPP indicated by each provider. Each row represents one provider.

Section 2: MLIU PPP

				MLIU PPP Goals			
RHP	TPI	Performing Provider Name	Performing Provider Type	DY7	DY8	Average Total PPP	MLIU Percentage of Total PPP
18	084001901	Collin County MHMR dba LifePath Systems	Community Mental Health	550	550	1100	50.00%
18	084434201	MHMR SVCS of Texoma	Community Mental Health	925	925	1550	59.68%
18	169553801	Tenet Frisco Ltd dba Centennial Medical Center	Hospital	300	300	600	50.00%
18	194997601	UHS Texoma, Inc. dba Texoma Medical Center	Hospital	750	750	900	83.33%
18	888888888	Provider A	Physician Practice affiliated with an	87.5	87.5	92.5	94.59%

J. *Regional Category C Summary* tab

This tab provides a summary of Performing Providers' selected Measure Bundles/measures, exemption requests, and points selected.

The Section 1 table displays the selected Measures Bundles/measures; number of PBCOs that are required or reporting as P4P; number of measures with requested achievement of alternative denominators (*all-payer denominator with significant volume, Medicaid-only denominator with significant volume, and LIU-only denominator with significant volume*); number of measures with requested shorter or delayed measurement periods; number of measures with requested reporting milestone exemptions (*Medicaid-only payer type* or *the LIU-only payer type*), and the points for the Measure Bundle/measure. Each row represents a Measure Bundle for hospitals and physician practices or a measure for LHDs and CMHCs.

Section 1: Measure Bundle/Measure Selection

TPI	Performing Provider Name	Bundle ID / Measure ID	Measure Bundle / Measure Name	# of PBCOs Required or Reporting as P4P	# of Measures with Requested Achievement of Alternative Denominators	# of Measures with Requested Shorter or Delayed Measurement Periods	# of Measures with Requested Reporting Milestone Exemptions	Points
111111111	Hospital A	C3	Hepatitis C	0	1	1	0	4
111111111	Hospital A	K1	Rural Preventive Care	0	1	0	1	7
169553801	Tenet Frisco Ltd dba Centennial Medical Center	D3	Pediatric Hospital Safety	0	0	1	0	10
169553801	Tenet Frisco Ltd dba Centennial Medical Center	I1	Specialty Care	0	1	0	1	2
194997601	UHS Texoma, Inc. dba Texoma Medical Center	A1	Improved Chronic Disease Management: Diabetes Care	0	1	1	0	11

The Section 2 table displays each provider's MPT and the total points selected. Each row represents one provider.

Section 2: MPT Summary

TPI	Performing Provider Name	MPT	Total Points in Selected Measure Bundles/Measures
084001901	Collin County MHMR dba LifePath Systems	25	28
084434201	MHMR SVCS of Texoma	10	9
169553801	Tenet Frisco Ltd dba Centennial Medical Center	1	3
194997601	UHS Texoma, Inc. dba Texoma Medical Center	10	8
888888888	Provider A	1	12

K. *Overall Template Progress tab*

This tab summarizes the completion of items from each tab that requires entry to determine if the full template is complete.

Step 16 **-** Review if any items show as *Incomplete* and resolve the issue. Once the template shows as *Template is COMPLETE,* then the file is ready for submission to HHSC.

ANCHOR RHP PLAN UPDATE TEMPLATE PROGRESS: **Template is NOT READY for submission to HHS.**

Please confirm that the Anchor RHP Plan Update template progress shows complete above. If it shows that the template is not ready for submission, please complete any missing steps and correct any outstanding issues before submitting to HHS.

Anchor Entry	
Section 2: Contact Information	Incomplete
RHP Organization	
Section 3: UC-Only Hospitals	Incomplete
Section 4: UC-Only IGT Entitites	Incomplete
Section 5: Collaborating Organizations	Incomplete
Community Needs Assessment	
Section 1: Updated Community Needs Assessment for DY7-8	Incomplete
Stakeholder Engagement	
Section 1: Extension Stakeholder Engagement Forum	Incomplete
Section 2: General Stakeholder Engagement	Incomplete
Learning Collaborative Plan	
Section 1: Learning Collaborative Plan	Incomplete

Step 17 **-** Once the template is ready for submission to HHSC, save the file with a name that includes the RHP used in the template, with no spaces: “RHP_XX_Anchor Template”. Submit the Anchor template and provider templates to HHSC through SharePoint.